Section 2: Population-Specific Prevention Needs

All residents of the District of Columbia need to be informed about HIV and provided with assistance to obtain the skills and motivation needed to protect themselves and others from infection with HIV. However, financial constraints affect the extent and intensity of primary HIV prevention efforts funded by the Administration for HIV/AIDS (AHA). As a result, the HIV Prevention Community Planning Committee (HPCPC) must focus attention on those populations that are at highest risk for infection. This section attempts to provide a description of the HIV prevention needs of several population groups and the barriers in reaching those populations, to help the HPCPC identify those most in need of prevention services and the best possible interventions for them.

Although this document identifies at-risk individuals by groups such as age, gender, sexual orientation and race/ethnicity, it should be clear that those factors do not place individuals at risk of infection. It is their behavior that may increase their risk, and it is these behaviors – and the causes for these behaviors – that are the intended focus of all prevention efforts.

In a 1993 presentation before a national summit on AIDS prevention, researcher Ron Stall, of the Center for AIDS Prevention Studies at the University of California at San Francisco, described the challenge this way: "As AIDS prevention efforts have evolved over the past decade, many high risk sub-populations have been identified for specialized interventions (young adults and adolescents, racial/ethnic minorities, female partners of high risk men, etc.). The identification of such groups for specialized AIDS prevention activities has never depended on causal arguments. For example, when specific racial minority groups are shown to be at high risk for the spread of HIV infection, no one asserts that it is race that causes elevated risk. Rather, race is assumed to be a marker for a complex set of social and psychological variables that result in higher risk for AIDS."

Various sources of information were used for this section, including focus groups with members of several target populations and needs assessments conducted by local providers. Because very few needs assessments have been done in the District, the bulk of the information in this section comes from studies done elsewhere and summarized in reports from the Center for AIDS Prevention Studies at the University of California San Francisco (CAPS) and the Centers for Disease Control and Prevention (CDC). Most of the information is supported by research, but some is anecdotal, based on the experiences of providers and consumers.

In viewing these materials, readers should be aware that the experiences described in studies done in California, New York or elsewhere may not generalize to other major U.S. cities, including the District of Columbia. Similarly, the risk behavior and other information gathered from participants in the various focus groups held in the District of Columbia may not generalize for other members of those populations.

Most of the studies mentioned in this section describe similar needs for all population groups:

1. There is a need for comprehensive prevention interventions – both for individuals and groups – that address the self-perception of risk, self-esteem, self-worth, and communication and negotiation skills.

2. Prevention programs should incorporate a multi-tiered approach, including mass media campaigns, material distribution, and one-on-one outreach interventions delivered by peers.

Contents of Section 2:

Adolescents and Young Adults

HIV infection is increasing most rapidly among young people. Half of all new infections in the United States occur in people younger than 25. (1)

Because of the long and variable time between HIV infection and AIDS, surveillance of HIV infection provides a much clearer picture of the impact of the epidemic in young people than surveillance of AIDS cases. The District of Columbia does not perform HIV surveillance, but a study that analyzed data from 25 states that have integrated HIV and AIDS reporting systems for the period between January 1994 and June 1997 found that young people (aged 13 to 24) accounted for a much greater proportion of HIV than AIDS cases (14% versus 3%). (2)

From 1994 to 1997, 44% of all HIV infections among young people aged 13-24 occurred among females, and 63% among African-Americans. While the number of new AIDS cases is declining among all age groups, there has not been a comparable decline in the number of new HIV infections among young people. (3)

The majority of young people are infected sexually. Among 13- to 24-year-olds, 52% of all AIDS cases reported among males in 1997 were among young men who have sex with men (MSM); 10% were among injection drug users (IDUs); and 7% were among young men infected heterosexually. In 1997, among young women the same age, 49% were infected heterosexually and 13% were IDUs. (2)

In the District of Columbia, adolescents and young adults (ages 13 to 24) accounted for 3% of all reported cases of AIDS among male adults/adolescents (13 or older), as of December 31, 1998. Among adult/adolescent women, those 13 to 24 accounted for 8% of the cases. (4)

Unprotected sexual relations put young people at risk not only for HIV, but also for other sexually transmitted diseases (STDs) and unintended pregnancy. Currently, adolescents are experiencing skyrocketing rates of STDs. Every year three million teens, or almost a quarter of all sexually experienced teens, will contract an STD. Chlamydia and gonorrhea are more common among teens than among older adults. (5)

Some sexually active young African-American and Latina women are at especially high risk for HIV infection, especially those from low-income neighborhoods. A study of disadvantaged out-of-school youth in the US Job Corps found that young African-American women had the highest rate of HIV infection, and that women 16-18 years old had 50% higher rates of infection than young men. (6) Another study of African-American and Latina adolescent females found that young women with older boyfriends (3 years older or more) are at higher risk for HIV. (7)

What puts adolescents at risk?

A 1997 survey of students in grades 9-12 in the District's public schools found that more than 71% of District teens (80% of males and 62% of females) had had sexual intercourse during their lifetime, and that 53% (58% of males and 49% of females) had sexual intercourse in the three months prior to the survey. (8) In a national survey 48.8% had ever had sexual intercourse. Black students in the national survey (72.7%) were significantly more likely than Hispanic and white students (52.2% and 43.6%) to have had sexual intercourse. (9) Black female students in the national survey (65.6%) were significantly more likely than Hispanic and white female students

(45.7% and 44.0%, respectively) to have had sexual intercourse. The District study does not break down the results by race/ethnicity.

In the District survey, 68% of the students who had sexual intercourse during the prior three months used a condom during their last sexual intercourse, compared with 56.8% in the national study. Black students in the national survey (64.0%) were significantly more likely than white and Hispanic students (55.8% and 48.3%, respectively) to report condom use.

Thirty-eight percent of students in the District survey had at least one drink of alcohol on one or more of the prior 30 days, compared with 50.8% of students in the national survey, and 12% of the District students drank alcohol or used drugs before their last sexual intercourse.

Eighteen percent of females and 16% of males in the District reported having ever been pregnant or getting someone pregnant one or more times during their lives. Nationally, female students (8.5%) were significantly more likely to have been pregnant than male students (4.7%) were to have gotten someone else pregnant.

Ninety-one percent of students the District study had been taught about HIV/AIDS in school, compared with 91.5% in the national survey. And 73% of the District students had ever talked about HIV/AIDS with their parents or other adults in their family, compared with 62.8% in the national survey.

Participants in a focus group sponsored by the District's HIV Prevention Community Planning Committee, held in August 1998, correlated a relationship between drinking, drugs and their choices to engage in unsafe sexual activity. Some participants said youth engage in risky sexual behavior "even though they know of the choices and risk."

Adolescence is a developmental period marked by discovery and experimentation that often includes sexual behavior and/or drug use. During this time of growth and change, young people get mixed messages. Teens are urged to remain abstinent while surrounded by images on television, movies and magazines of glamorous people having sex, smoking and drinking. Double standards exist for girls – who are expected to remain virgins – and boys – who are pressured to prove their manhood through sexual activity and aggressiveness. And in the name of culture, religion or morality, young people are often denied access to information about their bodies and health risks that can help keep them safe. (11)

A recent national survey of teens in school showed that from 1991 to 1997, the prevalence of sexually activity decreased 15% for male students, 13% for White students and 11% for African-American students. However, sexual experience among female students and Latino students did not decrease. Condom use increased 23% among sexually active students. However, only about half of sexually active students (57%) used condoms during their last sexual intercourse. (12)

Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. These include teens who are gay/exploring same-sex relationships, drug users, juvenile offenders, school dropouts, runaways, homeless and migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis, and have limited access to health care and service-delivery systems. (13)

Can education help?

Schools are an important venue for educating teenagers on many kinds of health risks, including HIV, STDs and unintended pregnancy. Across the U.S. and around the world, studies have shown that sexual health education for children and young people does not encourage increased sexual activity and does help young people remain abstinent longer. Effective educational programs have focused curricula, have clear messages about risks of unprotected sex and how to avoid risks, teach and practice communication skills, address social and media influences, and encourage openness in discussing sexuality. (14) In addition, HIV prevention programs that are carefully targeted to adolescents can be highly cost effective. (15)

Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible by prevention efforts. A national survey of youth aged 12-19 found that 9% were out of school. Out-of-school youth were significantly more likely than in-school youth to have had sexual intercourse, had four or more sex partners, and had used alcohol, marijuana and cocaine. (16) More intensive STD/HIV and substance abuse prevention programs should be aimed at out-of-school youth or youth at risk for dropping out of school.

Programs targeting hard-to-reach adolescents at high risk for HIV are necessary in many different venues outside of schools. Programs based in venues such as residential child care facilities, alternative schools and youth detention centers are needed. Peer educators can use an empowerment-oriented approach targeted to youth aged 12-17 to teach about preventing HIV and STDs, and to mobilize and link resources for young people through social and community networks. (17)

Families play an important role in helping teenagers avoid risk behaviors. Frank discussions between parents and adolescent children about condoms can lead teens to adopt behaviors that will prevent them from getting HIV and other STDs. Research has shown that when mothers talked about and answered questions about condom use with their adolescents prior to sexual debut the adolescents reported greater condom use at first intercourse and most recent intercourse, as well as greater lifetime condom use. (18)

What needs to be done?

Adolescents appear to change their behavior only if they receive repeated and consistent prevention messages; if they have the opportunity to develop the skills necessary to change their behavior; and if they have support for change from individuals and groups whom they can trust or identify with. (19)

HIV prevention programs for adolescents must consider the developmental needs and abilities of this age group. Programs should focus on contextual factors that lead young people to engage in higher rates of sexual activity and lower rates of condom use, such as low self-esteem, depression, substance use, gang activity, stress of living in turbulent urban environments, or boredom/restlessness related to unemployment. (5)

Any program for adolescents should be interesting, fun and interactive, and involve youth in the planning and implementation. This is especially true for out-of-the-mainstream youth and youth from diverse cultures. Programs for hard-to-reach youth who are most at risk for HIV infection should be implemented in venues outside of schools, such as runaway/homeless youth shelters, shopping malls, detention facilities and recreation/community centers. Adolescents not

only need correct information and practice in self-protective skills, but also easy access to condoms in order to keep themselves risk-free. (5)

Participants in the HPCPC-sponsored focus group recommended that more outreach workers be used throughout the community, to provide education and distribute free condoms, "especially" because most youth would not make special efforts to go to clinics for the help they need in order to prevent contracting HIV. (10)

The Center for Disease Control and Prevention recommends the implementation of a wide range of activities: (2)

School-based programs. Because risk behaviors do not exist independently - for example, a young person's ability to resist peer pressure and social influences to smoke are integrally related to the ability to say no to risky sexual activity - topics such as HIV, STDs, unintended pregnancy, tobacco, nutrition and physical activity should be integrated and ongoing for all students in kindergarten through high school. Research has clearly shown that the most effective programs are comprehensive ones that include a focus on delaying sexual behavior and provide information on how sexually active young people can protect themselves.

Community-based programs. Addressing the needs of adolescents who are most vulnerable to HIV infection, such as homeless or runaway youth, juvenile offenders, or school dropouts, is critically important. Community outreach programs play an important role in reaching these young people.

Sustaining prevention efforts for young gay and bisexual men. Targeted, sustained prevention efforts are urgently needed for young MSM as they come of age and initiate high-risk sexual behavior. Ongoing studies show that both HIV prevalence and risk behaviors remain high among young MSM. In a sample of young MSM ages 15-22 in 6 urban counties, researchers found that, overall, between 5% and 8% were infected with HIV. HIV prevalence was higher among young African-Americans (13%) and Hispanics (5%) compared with young white MSM (4%).

Need to address sexual and drug-related risk. Many students report using alcohol or drugs when they have sex, and 1 in 50 high school students reports having injected an illegal drug. Surveillance data from the 25 states with integrated HIV and AIDS reporting systems between January 1994 and June 1997 showed that drug injection led to 6% of HIV diagnoses reported among those aged 13-24 during that time period, with an additional 57% attributed to sexual transmission (26% heterosexual, 31% from male-to-male sex).

Role of STD treatment in comprehensive HIV prevention programs for young people. An estimated 12 million cases of STDs other than HIV are diagnosed annually in the United States, and about two-thirds (roughly 8 million) of those are among people under the age of 25. A large body of research has shown that biological factors make people who are infected with an STD more likely to become infected with HIV if exposed sexually; and HIV-infected people with STDs also are more likely to transmit HIV to their sex partners. Expanding STD treatment services is critical to reduce the consequences of these diseases and to help reduce the risks of transmitting HIV among youth.

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African-Americans

African-Americans have been disproportionately affected by HIV and AIDS. Through December 1998, the Centers for Disease Control and Prevention (CDC) had received reports of 251,408 cases of AIDS among African-Americans. Although that is 37% of the 688,200 cases reported, African-Americans represent only an estimated 13% of the total US population. (1) Approximately 1 in 50 African-American men and 1 in 160 African-American women are believed to be infected with HIV. (2)

In the District of Columbia, Blacks account for 8,491 of the total 11,369 cases of AIDS reported as of December 31, 1998. Blacks represent 63% of the District's population (3), but account for 79% of AIDS cases. (4)

Who are African-Americans at risk?

While African-Americans are often viewed as one group, there is, in fact, a wide variety of populations in the U.S. included under this heading. (5) Upper class, lower class, Christian, Muslim, inner-city, suburban, descendants of slaves and recent Caribbean immigrants all come under the African-American heading. Current epidemiological surveillance does not record these social, cultural, economic, geographic, religious, and political differences that may more accurately predict risk. (6)

HIV transmission in African-American communities is often viewed as a problem among heterosexual injection drug users (IDUs) and their sexual partners. But in the District of Columbia, as of December 31, 1998, 52% of the cases among Black adult/adolescent men were among men who have sex with men, and 30% among IDUs. Among Black women, 57% of the cases were among IDUs and 35% got infected through heterosexual contact. (4)

Injection drug use has played a major role in HIV infection among African-Americans. African-Americans are twice as likely as whites to have used drugs intravenously, and HIV infection is higher for black IDUs than white IDUs. (7) One reason may be that many blacks reside in inner-city areas where drug trafficking, unemployment and poverty, among other factors, have assured that blacks suffer high rates of addiction. (8) Studies of drug users that describe significant association between health and race may be better explained by these characteristics of the social environment. (9)

What puts African-Americans at risk?

Very little information exists on risk factors specific to African-Americans, especially among IDUs, because until recently there has been a lack of research in this area. (10) Funding agencies have not targeted African-Americans as a particular area of concern for research. Few non-minority researchers have demonstrated ongoing interest in intervention work with African-Americans, and currently less than 3% of National Institute of Health research grants are awarded to African-American researchers. (5)

In a survey of African-American gay and bisexual men in the San Francisco Bay Area, more than 50% reported unprotected anal intercourse, a considerably higher percentage than among white gay men. Those men were more likely to be poor, to have been paid for sex, or to have used injection drugs; to engage in unprotected sex despite knowing the risk of HIV infection; and to report less social support. Men with negative expectations and beliefs about condoms were less likely to use them. (11)

Among African-American adults living in cities with a high prevalence of AIDS cases, almost one-fifth (19%) reported having two or more sexual partners in the past year. More men (30%) than women (10%) reported multiple partners. Substantial proportions of blacks with multiple sex partners used no condoms with either their main (47%) or secondary partners (35%). (12)

What are obstacles to prevention?

Many members of the black community have held an underlying distrust of the white public health world, especially since the Tuskegee Syphilis Study. Some groups, including some African-Americans, believe that the effects of AIDS on the community are the results of deliberate efforts of the US government. Adding to this are persistent inadequacies in social benefits, health care, education and opportunities for African-Americans. Effective prevention programs must address these concerns. (13, 14)

Among homosexually active African-American men, including those who self-identify as gay, fear of homophobia and strong attachment to the minority community may have been strong disincentives to respond to AIDS as a primarily gay issue. At the beginning of the epidemic, the absence of national gay leaders and large gay constituencies in the African-American population offered few opportunities to mobilize support. (15)

What's being done?

Not many prevention programs specific to African-Americans have been evaluated for effectiveness, but the number of programs is increasing and there are a few promising studies. (2) An intervention aimed at African-American gay and bisexual men extensively pilot tested all materials including videos that depicted only black men and addressed issues related to the men's same-sex attitudes and behaviors addressed in their own words. Clients who participated in three weekly, three-hour group sessions greatly reduced (50%) their frequency of unprotected anal intercourse, and maintained the behavior change through an 18-month follow-up. (15)

African-American male adolescents in Philadelphia, PA took part in an intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and weaken problematic attitudes towards risky sexual behaviors. Educational materials included a video narrated by a black woman with a multiethnic cast and "AIDS basketball" where teams earned points for correctly answering AIDS questions. Participants reported less sexual intercourse, fewer partners, and greater use of condoms after the intervention. (16)

Men and women attending an STD clinic in the South Bronx, NY had access to either a video on condom use, or both the video and an interactive group session. Patients were given coupons for free condoms at a pharmacy several blocks from the clinic. Among African-American clients, condom acquisition increased substantially after the video and group session, but not after the video alone. One reason may be that the video primarily targeted behavior change among men. Also, clients who self-identified as Caribbean had lived in the US for a shorter amount of time, and the video may have been embedded in US culture. This study showed that interactive sessions combined with videos can personalize the prevention message and enhance behavior change. (17)

What needs to be done?

Researchers and service providers need a better understanding of the role of cultural and socioeconomic factors in the transmission of HIV, as well as the effect of racial inequality on

public health. In addition, public health officials should consider changing epidemiological surveillance to include other demographic information besides sex, age and ethnicity. These efforts need to influence the design of prevention messages, services and programs. (2)

In the second decade of the AIDS epidemic, few studies of HIV prevention interventions specifically for African-Americans have been conducted or published. (18) Especially lacking are studies of African-American IDUs and gay/bisexual men. (19)

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African-American Men

Black men represent 58% of all men in the District of Columbia 15 or older (1), but account for 70% of all AIDS cases among men 13 or older. (2). Of the cases among adults/adolescents Black males reported in the District as of December 31, 1998, 52% were among men who have sex with men, and 30% among IDUs. Heterosexual contact accounted for 7% of AIDS cases among Black men.

A 1997 study of 502 African American men in California found high-risk sexual practices were relatively prevalent among group members, and a high percentage reported a history of STDs and other infections. In addition, 25% had a current psychiatric disorder, with gays/bisexuals and HIV+ individuals evidencing greater psychiatric vulnerability. The sample was primarily HIV- (63%) and heterosexual (49% gay or bisexual) and a high percentage used substances during the past year (56% used drugs and 30% were moderate/heavy drinkers). (3)

The authors state that, "More research is needed to further explore the apparent greater risk for psychiatric disorders among gay and bisexual men, and to determine whether being African American and lower social class exacerbate this risk."

A 1992 study on difference in knowledge about AIDS, attitudes about condoms and sexual behavior among African-American men and women indicated that the groups did not differ in their knowledge about AIDS. However, attitudes about condom use differed significantly by gender and by multiple sex partner status. Of the 149 men, 71 (47%) were classified as having multiple sex partners and 78 (53%) as having one sex partner. Of the 165 women, 29 (19%) were classified as having multiple sex partners and 126 (81%) as having one sex partner. (4)

Angry reactions regarding the negotiation of condom use occurred more with men than with women, and men and members of the multiple sex partners group tended to engage in more risky sexual behavior. These two groups also had a significantly higher incidence of gonorrhea. The results indicate that African Americans are knowledgeable about AIDS, but there appears to be a gap between knowledge and risky sexual behaviors.

A 1994 study that analyzed the differences in risky sexual behavior between African-Americans and whites found that attitudes about the use of condoms differed significantly by multiple partner status and gender, but not by ethnicity, that whites were more likely to engage in anal and oral sex, and that African-Americans were more likely to have sex with prostitutes. Subjects with multiple sexual partners were more likely to use drugs and

practice risky sexual behaviors such as having anal intercourse, having sexual experiences with a prostitute, and having a history of gonorrhea and genital warts. (5)

While whites reported a greater use of drugs and a significantly higher level of knowledge about HIV/AIDS, African Americans reported a significantly greater perception of risk for being exposed to HIV and significantly more gonorrhea, syphilis, and HIV/AIDS. No whites in the sample had tested HIV+, but 4.5% of the total sample of African Americans reported testing HIV+.

A 1995 study of beliefs related to prevention of AIDS and HIV infection among African-American teenagers found that teens simultaneously believed in the importance of safe sex behaviors while expressing doubt about the viability of some safe sex behaviors. Females demonstrated higher self-efficacy and self-control beliefs, while males were more likely to endorse culturally loaded suspicious beliefs about AIDS contraction and transmission. (6)

In addition, those teenagers who perceived themselves as highly knowledgeable scored lower on reliable AIDS Knowledge and Prevention Beliefs measures than those who claimed moderate AIDS knowledge. Some of these "Know It All" teenagers may reflect a subculture of pseudo-confidence that requires special interventions.

A 1993 study of low-income, urban, African-American and Hispanic youth in Detroit found substantial ethnic and gender differences in risk behaviors. Young African-American men reported the earliest initiation of sexual activity and the most partners, while young Hispanic women reported the latest initiation of sexual activity and the fewest partners. (7)

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African-American Women

Black women represent 62% of all women in the District of Columbia 15 or older (1), but account for 94% of all AIDS cases among women 13 or older. (2) Of the cases among Black female adults/adolescents reported in the District as of December 31, 1998, 57% were among injection drug users, while heterosexual contact accounted for 35% of the cases.

Nationally, HIV/AIDS was the leading cause of death among African-American women aged 25-44 in 1997. (3) Today, AIDS-related deaths among women are decreasing, largely as a result of recent advances in HIV treatment. However, AIDS deaths among women are not declining as rapidly as AIDS-related deaths among men.

Over the past decade, the AIDS epidemic in the U.S. has increased most dramatically among women of color. Prior to the impact of new combination drug therapies to treat HIV infection, AIDS incidence was increasing at rates of 15% to 30% each year among African-American and Hispanic women. (3) African-American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (76%) of AIDS cases reported to date among women in our country.

In a study of African-American women 40 years or older living in low-income housing development in five US cities, 23% of the women believed that birth control pills protect against HIV and 20% though that cleaning injection needles with water kills the AIDS virus. While few of the women in the 1998 study reported multiple sexual partners in the previous two months (3%), 36% of women had a primary sexual partner who engaged in high HIV risk activities. (4) The study found that high risk women were in their early-40s, reported weaker risk reduction behavioral intentions, more frequently talked to their male sexual partner(s) about AIDS, and perceived their housing development to be unsafe.

A study of young African-American women residing in a low-income community in San Francisco found that women who perceive that conflict will result from safer sex negotiation are significantly less likely to use or intend to use condoms in their relationships. Only 22% of the women used condoms at every sexual intercourse in the past two months, and 90.3% expected some conflict as a consequence of initiating safer sex negotiations with their partner(s). (5)

Women with low perceptions of conflict, as compared to those with high conflict expectations, were 1.9 times more likely to use condoms consistently, 1.9 times more likely to intend to use condoms in the future, and 1.7 times more likely to have a partner who uses condoms without discussion.

A 1998 study of African-American women in Alabama found the prevalence of non-condom use was 45.3%. Women whose sexual partners were non-condom users were four times more likely to believe that asking their partner to use a condom implied he was unfaithful, three times as likely to have a partner who resisted using condoms, and twice as likely to be sexually nonassertive. (6)

Compared to women who were not abused during childhood, women who reported a history of childhood sexual abuse were 2.6 times as likely to have a partner who was physically abusive when asked to use condoms, 1.4 times more likely to report having an STD, 2.4 times as likely to report having greater than two lifetime STDs, 3.8 times as likely to have a history of anal sex, and 2.6 times as likely to worry about acquiring HIV. (6) They were also 1.5 times more likely to

have had an abortion, 3.9 times more likely to believe their partner did not care for them, twice as likely to doubt the longevity of their relationship, 5.1 times as likely to have a partner who had been physically abusive within the previous 3 months, and 1.5 times as likely to consume three or more glasses of alcohol at one time. Childhood sexual abuse was defined as experiencing forced sex prior to age 16.

A 1997 study of inner-city African-American women in Wisconsin found that one third of the participants were at high risk for HIV either because they had multiple partners or because of the high-risk behaviors of their regular partner. HIV risk was highest among women who accurately perceived themselves to be at increased HIV risk, reported weak behavioral intentions to reduce risk, and held stronger beliefs about psychosocial barriers to condom use. (7)

Women at high risk were also younger, reported higher rates of substance use, and indicated that their housing development lacked social cohesiveness. The authors said these findings suggest that HIV prevention efforts for this population should focus on strengthening women's risk reduction behavioral intentions and self-efficacy through skill development, overcoming psychosocial barriers to condom use, managing the risk related to substance use, and incorporating approaches that take into account the social, psychological, and relationship barriers to change among economically impoverished African American women.

A 1996 study in Virginia on HIV prevention for African-American women found that AIDS information and street outreach for this population is most effective when introduced by another African-American woman. The study also found that church support, participation from key community leaders, and women living with HIV/AIDS is critical in educating this hard to reach population. (8)

Participants in a DC focus group for African-American women who reside in public housing projects, held in August 1998, called for free condom distribution on the streets in their communities and educational programs for young people, particularly peer education programs for teenage girls. (9)

Preliminary results from a 1998 study on the impact of a six-session AIDS prevention intervention for low-income inner city African-American women in Illinois found "significant effects" across time for positive attitudes about condom use, knowledge of condom use, self-efficacy to stick to a decision to use condoms, and increased low-risk AIDS behavior. (10) It also found that culturally-specific AIDS prevention interventions based on social learning theory and taught by peer leaders are helpful in promoting attitudes and behaviors conducive to the reduction of HIV/AIDS.

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Blind / Handicapped

There is little national data on HIV/AIDS cases or behavioral studies of persons with disabilities and the blind or partially sighted, and none of residents of the District of Columbia. Because of this, these populations are often neglected when considering the HIV prevention needs of various populations.

The blind and partially sighted may have difficulty in obtaining appropriate HIV information because a high proportion of HIV prevention is disseminated through visual messages on television and in newspapers, brochures and other written media. Currently there are no publicly funded prevention programs that specifically target the blind or partially sighted.

A 1996 survey conducted in Marseilles, France, to evaluate the HIV prevention needs of blind people, found that 82% of participants felt they were are poorly informed and wanted to receive a more complete and better adapted information. Seventy-two percent said they would welcome "with enthusiasm" the idea of being able to consult some documents adapted to their handicap, and 69% of blind adults and parents were in favor of this approach, because it facilitates dialogue within the family. (1)

The level of risk in the disabled community is not well known because there is no tracking mechanism in place to determine the number of AIDS cases among people with disabilities, and the notion that disabled individuals are not sexually active or are not substance abusers. A 1996 study in Togo found that the precarious living conditions of handicapped persons, particularly girls, leads them to get involved in prostitution, making them vulnerable to HIV infection. In addition, existing education programs do not consider the needs of the handicapped population, relying on targeted groups to go where the activities take place, "something which very evidently hinders the participation of handicapped persons." (2)

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Chronically Mentally Ill

Recent seroprevalence studies have shown high rates of HIV infection among severely mentally ill men and women in large urban areas, and HIV behavioral epidemiology research indicates that a substantial proportion of seriously mentally ill adults engage in activities that increase their vulnerability to HIV/AIDS. (1) Their cognitive impairment, affective instability and impulsivity are likely to result in behaviors associated with HIV infection — namely unsafe sexual practices and injection drug use. (2)

There are no surveillance or behavioral studies among the chronically mentally ill in the District of Columbia. Participants in a September 1998 focus group for chronically mentally ill African-Americans in the District demonstrated a basic knowledge about HIV/AIDS modes of transmission and risk reduction behaviors. The participants identified several reasons why individuals choose not to use condoms, including: “they don’t think they can get the virus;” “they don’t care,” “it feels good without a condom;” “uneducated” and “they trust the partner because he or she looks good on the outside.” (3)

A seroprevalence study of patients admitted to a Maryland state psychiatric hospital between August 1990 and July 1991 found that 5.8% were infected with HIV. The prevalence of HIV infection was 36.4% among female patients reporting intravenous drug use and 14.5% among their male counterparts. The prevalence of HIV infection among homeless patients was 10.1%; 88.9% of those HIV infected also reported intravenous drug use. On admission, 90% of patients reported no knowledge of their HIV antibody status; 4.1% of these patients were HIV infected. (4)

A review of research literature that has investigated HIV-related risk behavior among adults who have a severe and persistent mental illness indicates that they engage regularly in practices known to involve increased risk for HIV transmission. (5) Impulsivity, high levels of sexual activity during acute exacerbation of psychiatric illness, poor skills at negotiating safe sex, homelessness and drug abuse are all risk behaviors common among those affected by some mental illnesses. (6)

A study done in Brazil in 1995-1996 found that only 23.8% of men and 24.2% of women used condoms regularly. The study also found that a history of sexual abuse was common among this population (32.3% of women and 19% of men), and that 17.2% of women and 14.3% of men sometimes exchanged sex for money or drugs. (7)

A 1996 study in Milwaukee among chronic mentally ill adults receiving services in urban community-based mental health programs found that women had more frequent unprotected intercourse, more coercive sex, and engaged in survival sex and substance use prior to sex more often than men. (8)

The study showed that 27% of all patients had had two or more sex partners in the previous year and 18% had received money or drugs for sex. High rates of illicit drug use were also found, with frequent use of drugs or alcohol in association with sexual activity. Multiple regression analyses showed that use of illicit drugs, meeting sex partners in psychiatric clinics, and meeting partners in bars accounted for a substantial proportion of the variance in HIV risk behavior.

A study of HIV risk behavior among homeless mentally ill men in a New York City shelter found that 49% had anal or vaginal intercourse during the previous six months, but only 25% of the 44 sexually active men had used condoms all the times they had intercourse. A previous study reported a 19% HIV prevalence among these men. (9)

Thirty-one percent had intercourse with women only, 7% with men only and 11% with both men and women. Eighteen of the 38 who had sex with women had given drugs or money in exchange for sex, while 11 of the 16 who had sex with men had received drugs or money in exchange for sex.

A 1993 study among Milwaukee outpatients with multiple or high-risk partners found that chronic mentally ill individuals lack knowledge about HIV transmission, are not sensitized to risk, and have low self-efficacy and safe-sex skills. (10)

The ability of study participants to identify sexual behaviors as safe or unsafe was extremely poor. Although 68% said they were at little risk for HIV infection, 40% had unprotected vaginal intercourse in the last month. On the condom use assessment, only 4% of the sample performed the entire task correctly; 33% a chose non-latex condom and 20% were unable to roll out the condom in the right direction.

A review of literature on HIV prevention interventions for this population showed that intensive, small-group interventions that target a variety of risk-related dimensions-including knowledge, attitudes, and motivations, and behavioral and cognitive skills-can produce at least short-term reductions in high-risk sexual behavior among the severely mentally ill. The review also identified several gaps in the research literature, including the need to: (a) better tailor interventions to risk situations encountered by the mentally ill; (b) develop gender-tailored interventions; (c) examine and implement HIV prevention programs so they help persons sustain behavior change; (d) explore one-on-one counseling and community-level intervention methods; and (e) develop risk reduction interventions for already-seropositive individuals. (1)

In a Milwaukee study, 27 men and 25 women were randomly assigned either to a four-session AIDS prevention program emphasizing risk education, sexual assertiveness, condom use, risk-related behavioral self-management, and problem-solving skills or to a waiting-list group, who later received the same intervention. Compared with the waiting-list control group, participants in the prevention program demonstrated significant gains in AIDS-related knowledge and intentions to change risk behaviors. (11)

The prevention program also significantly reduced rates of unprotected sexual intercourse and increased the use of condoms over a one-month follow-up period. A subset of participants who provided two-month follow-up data maintained some behavior change. (11)

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Commercial Sex Workers

Many commercial sex workers who work on the street, most of whom are poor or homeless, and many of whom are young, have a history of childhood abuse and are likely to be drug or alcohol dependent. Street prostitutes are extremely vulnerable to violence from clients, police, and sometimes their lovers. Male and female sex workers who work off the street (in brothels,

massage parlors, their own apartments or with escort services) are much less likely to become infected, largely because they are less likely to depend on drugs or alcohol and more likely to be able to control the sexual transaction and insist on condoms. (1)

There are no seroprevalence or behavior studies of commercial sex workers in the District of Columbia. Participants in a DC a focus group for transgender sex workers, held in August 1998, were fairly knowledgeable about HIV transmission and risk behavior, and were confident about how to use condoms. Participants gave several reasons for engaging in risky behavior, including that it "feels better" not to use condoms for intercourse. Other reasons were: the partner might talk the person into it, the person may not be educated about HIV, and the person may not think he/she will get HIV. (2)

Five of the nine participants knew of HIV/AIDS programs or services in their communities and four knew of outreach services, such as the Helping Individual Prostitutes Survive (HIPS) program, but several felt that "most people" did not know about these programs. Four participants said they were not familiar with any HIV prevention activity or program in their area. (2)

A study of 1,396 female sex workers in six US cities found an HIV seroprevalence of 12%, ranging from 0-47.5% depending on the city and the level of injecting drug use. (3) A study of 235 male street sex workers in Atlanta, GA, found 29.4% seroprevalence, with the highest rates among those who had receptive anal sex with nonpaying partners. (4)

What puts sex workers at risk?

Injection drug use was the main risk factor for HIV infection for female prostitutes in six US cities. (2) Female injection drug users who trade sex for money or drugs are more likely to share needles than female injectors who do not engage in sex trading, and are less likely to use new needles or to clean old ones. (5)

Drug use can increase both the likelihood of sex work and unsafe sex. A study of crack cocaine users recruited from the streets in three urban neighborhoods found that 68% of women who were regular crack smokers had exchanged sex for drugs or money. Of those, 30% had not used a condom in the past 30 days. (6)

Recently, observers have found an association between HIV infection and heavy crack use and unprotected fellatio. This may be due to poor oral hygiene and damage to the mouth from crack pipes, high frequency of fellatio, and inconsistent condom use. (7)

Sex workers may agree to unprotected sex if a client offers substantially more money, if they are desperate for money to buy drugs, or if business has been slow. In some cases, clients may use violence to enforce unsafe sex. Police in many cities routinely confiscate condoms when they arrest or stop prostitutes, and prostitutes may not be able to obtain more condoms immediately. Thus, in some situations, sex workers are powerless to insist on condoms for safer sex. (8)

Like many people in committed relationships, sex workers may find it difficult to discuss condoms or safer sex practices with their partner at home. In one study, although 94% of sex workers used condoms at some point with their clients, only 25% had used condoms with their partners at home. (9)

What are barriers to prevention?

The illegality of prostitution in the US drives the industry underground and engenders a strong distrust of both police and public health authorities among sex workers. This makes effective HIV prevention outreach difficult. (8)

Desperation and lack of resources can override prevention concerns. Drug-addicted people may turn to prostitution to earn money to pay for the high cost of illegal drugs, and many homeless youth have no training or means of support, and rely on prostitution for survival. Attention to the more immediate concerns of food, housing and addiction often takes priority over future concerns of HIV infection. (8)

What's being done?

Some rural counties in Nevada have legal prostitution governed by the state Board of Health. The Board requires that condoms be used for all acts of sex and that sex workers must be licensed and undergo weekly STD tests and monthly HIV tests, at their own expense. (10) As of 1993, no women tested positive out of a total of 20,000 HIV tests of sex workers. (11) Licensed prostitutes receive no sick leave or health insurance, and if they tested HIV+ they would be terminated without counseling or assistance. (10)

The California Prostitutes' Education Project (CAL-PEP) provides condoms, STD/HIV testing, AIDS education and drug treatment referral through regular and repeated street outreach. Outreach workers are former prostitutes who are trained in AIDS prevention. The project successfully encouraged prostitutes to use condoms regularly on the job but found it difficult to influence condom use in private relationships. (9)

On the Streets Mobile Unit-Options in New York City, NY runs vans that bring over 4,000 street prostitutes friendship, food, clothes, condoms, HIV/STD testing and counseling and needle exchange. They also help prostitutes get public assistance and/or drug treatment. Rates of HIV infection among clients have declined since 1989. (12)

The Threshold Project in Seattle, WA helps homeless youth acquire the skills necessary to live independently without sex work. Most of the clients in this program had been emotionally, physically, or sexually abused. The two-year program offered a series of progressively more independent living experiences, and in follow-up, 42% of participants remained in stable living situations without sex work. (13)

When free methadone maintenance was offered to heroin-addicted street prostitutes in southern California, most enrolled. After one year, personal income from prostitution and other crime was reduced 58% and income from legal sources increased 86%. (14)

Internationally, many HIV prevention efforts aimed at sex workers have addressed structural and policy considerations. In Thailand, the Ministry of Public Health began a 100% condom-use program in all sex establishments in several provinces. After the intervention in Samut Sakhon province, the number of condoms used increased from 15,000 to 50,000 a month, and STD incidence decreased from 13% to 0.3-0.5%. (15)

In Bulawayo, Zimbabwe a multiplicity of approaches reached sex workers and clients. AIDS training targeted nurses and health care professionals, as well as non-conventional audiences such as hotel and bar workers and taxi drivers. Community outreach relied on sex worker and

client peer educators and provided widespread condom distribution. STD services in the city were also strengthened. (16)

What still needs to be done?

In the US, HIV research among prostitutes has focused largely on their role as vectors of infection for the general public. To prevent HIV infection among prostitutes, it is essential to address the context in which sex work is transacted, as well as the specific practices of the prostitutes. Placing the major burden for HIV prevention on prostitutes themselves may not be the most effective tactic. Economic dependence and gender power imbalances can make it nearly impossible for prostitutes to demand safer sex. Laws and police attitudes towards carrying condoms must be eased to allow sex workers to protect themselves. Decriminalizing prostitution and regulating sex businesses would remove many obstacles to consistent condom use and safer sex. (17) Clients and brothel/ escort service owners also need to be more actively targeted in prevention programs. (8)

Increased funding is needed for prevention programs that address the full range of problems sex workers face, both on and off the streets, especially programs staffed and managed by peers. Drug treatment, housing, child care and skills training for prostitutes are essential. Better health care services are needed for prostitutes, including diagnosis and treatment for STDs/HIV, care for injuries due to violence, and mental health care. A comprehensive HIV prevention strategy uses a variety of elements to protect as many people at risk as possible. Sex workers require a broad range of protective services, including HIV prevention. (8)

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Deaf and Hearing Impaired

There are approximately 20 million deaf and hearing impaired (D&HI) people in the United States, according to the National Center for Health Statistics, and between 325 and 450 D&HI individuals were living with AIDS as of January 1998, according to the Deaf AIDS Project of Maryland's Family Service Foundation. (1) There is no data on the incidence of HIV or AIDS among D&HI in the District of Columbia, and only one survey on behavior that might place members of that community at risk for HIV infection.

A 1995 survey of students at Gallaudet University in the District of Columbia – which provides services to the deaf and hearing impaired – found that 50% of the 84 respondents did not use condoms during heterosexual sex, and that 95% did not use condoms during oral sex. Most of the respondents (86%) obtained their information about HIV/AIDS from newspapers, books and magazines. (1)

The deaf are particularly vulnerable to HIV infection because of language barriers, their unique culture, and the paucity of community services, educational programs, and general information directed to this population. (2) A 1992 study estimates that the deaf population is about eight years behind the hearing population in HIV knowledge and awareness. (3)

A 1989 study by the Ontario Association of the Deaf (4) found that:

1. Profoundly deaf persons whose primary language is American Sign Language generally have limited English skills, usually below grade 4 level. Thus, current AIDS materials are inaccessible to them.

2. AIDS information is passed socially from one deaf person to another rather than through mass media. Misconceptions are spread quickly and are extremely difficult to challenge without direct access to deaf social networks.
3. Models of community development used by most AIDS organizations are not appropriate for the deaf community. Consistent leadership from the deaf community is critical to the development of a culturally-relevant, cost-effective and efficient AIDS and Deafness Program.

Efforts have been made to reach the deaf community through targeted HIV/AIDS education, but some findings indicate that D&HI individuals, many of whom are isolated from hearing communities due to linguistic and cultural distinctions, may not be completely receiving the messages. Studies show that deaf adolescents have large information gaps concerning HIV transmission and prevention. (3) A 1993 study in Colorado found important gaps in adolescents' knowledge of how HIV and AIDS are transmitted and prevented and who can get HIV. (5)

Deaf college students were found to be better informed, but their knowledge does not correlate with reduced risky behavior. Diagnosis of HIV for many deaf people often does not occur until the patient is symptomatic, and HIV+ deaf people tend to die earlier than hearing patients. A delay in treatment resulting from lack of patient knowledge and comprehension of HIV may account for these findings. (3)

The particular barriers that the deaf must face in learning about HIV protection range from inadequate schooling about human sexuality to the scarcity of locally available education programs. (4) In Colombia, a 1996 study found that D&HI individuals do not have access to HIV prevention information in the media or educational brochures because 95% of them are illiterate. As a result of the study, the National AIDS Program is developing a mass media campaign that uses sign language to decrease the isolation and lack of communication of the D&HI. (6)

A 1998 study in Cincinnati among persons whose primary language is American Sign Language found that participants were less likely to associate sexual contact with drug users and number of sexual partners as high-risk sexual behaviors. They also believed they did not need to change their sexual behavior as a result of the AIDS epidemic. The study also found differences in receiving, trusting, and/or being exposed to current information about AIDS, consistent with the fact that they are a minority population with distinct knowledge and cultural traditions. (7)

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Ex-Offenders

There are no seroprevalence or risk behavior studies of ex-offender in the District of Columbia, but participants in a District of Columbia focus group, held in August 1998, discussed their own shortcomings in safer sex practices, saying that they did not use condoms even when they had them in their possession in order not to "miss the moment" or "interrupt the flow." Other reasons for not using condoms for intercourse included requests from their sexual partners, and the "feel" of condoms and how it affected the intimacy and closeness of the sex act. (1)

They also spoke about the effects of crack cocaine on diminishing penile erections. This phenomenon was cited as a reason that an individual, who could only achieve a weak erection under the effects of the drug, would not wish to use a condom which would reduce sensation and risk loss of erection.

The group consensus was that prevention services in the District of Columbia are good but that more programs are needed and that there should be widespread distribution of free condoms.

(For additional information on this population, please see the section on Incarcerated individuals.)

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Gay/Bisexual Men

HIV-related illness and death have had the greatest impact on men who have sex with men (MSM). Even though the toll of the epidemic among injection drug users (IDUs) and heterosexuals has increased during the last decade, MSM continue to account for the largest number of people reported with AIDS each year. (1) In the District of Columbia, MSM account for 51% of all AIDS cases reported as of December 31, 1998, and for 63% of cases among adult/adolescent men, 91% of cases among white men, 51% of cases among Black men and 72% of cases among Hispanic men. (2)

The US Census Bureau estimates the adult/adolescent male population of the District of Columbia at 201,263 as of 1997. Of these, an estimated 10% (20,126) are gay or bisexual males.

Nationally, the estimated number of AIDS diagnoses each year (AIDS incidence) among white MSM has been declining since 1993, reflecting in part the success of prevention programs in these communities. Yet, AIDS incidence among African-American and Hispanic MSM continued to increase until 1996, when new treatments began to have an impact on trends in these populations. The new combination drug therapies have now slowed the progression from HIV to AIDS in many people, resulting in fewer AIDS diagnoses among all populations, but the declines have not been as significant among MSM of color as among white MSM. (**1**)

In 1990, MSM accounted for 73.2% of AIDS cases in the United States, but declined to 68.7% in 1994. Most of the decline occurred in white MSM, whose percentages declined from 51.2% to 45.5%. No such declines were observed for African-American, Asian-American, or Native-American MSM. (3)

Why are some men still taking risks?

Continuing safer sex behavior over a long time is difficult. For many men in the gay community, the challenge is not to start having safer sex, but to do so consistently and for the long haul. (4)

In the second decade of the epidemic, the gay community is struggling with the fact that AIDS is here to stay, and that the prospect of a cure is far away. Overwhelming psychological, cultural and spiritual issues surrounding living in the midst of an epidemic often overcome the ability or desire to remain uninfected. (5)

In a 1998 survey of more than 7,000 gay, bisexual and homosexually active men by New York City's Gay Men's Health Crisis (GMHC), 13% of the men said they were HIV+, 73% said they were HIV-, and 13% didn't know. Black men had the highest HIV+ rates (17%) followed by Latinos (15%), whites (13%) and Asian and Pacific Islander men (2%), confirming earlier reports that Black and Latino gay men are the hardest hit by HIV. (6) Asian/Pacific Islander men were less likely to have been tested than other races/ethnicities, as were men under 24 and men 60 and over.

Some 39% of men reported unprotected anal intercourse (UAI) in the previous year, while 50% percent of the men reported either no anal sex or anal sex only with a condom. Twenty-one percent had unprotected anal intercourse with someone whose HIV status was different from their own or unknown. (6**)**

Among the men who had receptive UAI in the previous year, 70% had intercourse with only one man, while 66% of the men who had insertive UAI had intercourse with only one man. Among HIV- men, 77% had receptive UAI with only one partner and 71% had insertive UAI with only one partner.

Recently, a small minority of both HIV-positive and negative men have begun to "consciously, willfully, and proudly" engage in unprotected anal sex. The new phenomenon – referred to as "raw," "skin-on-skin," or "bareback" sex – may be linked to the perceived effectiveness of protease inhibitors and the promise of "morning after" exposure treatment. It is unclear how many men are engaging in such defiantly premeditated, risk behavior. Michelangelo Signorile suggests that the number is "small, but growing." (7)

The barebacking phenomenon can be seen as a reaction to prevention efforts that have failed to adequately address the complex meanings of sexual behavior in relation to the divergent

identities that have developed around HIV serostatus. Moreover, prevention campaigns have not adequately addressed the different needs of negative and positive men. (7)

What's working now?

HIV prevention programs using small group counseling, community outreach, community mobilization, stress reduction counseling, peer education, and skills training have been effective among all segments of MSM: men in epicenter cities, men in rural communities, young men, adolescents, men of color, and bisexual men. (8)

AIDS education led by peers on a community level is effective at reaching higher-risk men. In several medium-sized towns, the most popular people in social settings were trained to deliver AIDS risk-reduction messages to their friends and acquaintances in gay bars. As a result, fewer men practiced unprotected sex. (9)

The STOP AIDS Project, which grew out of focus groups conducted early in the epidemic in San Francisco, CA, uses community outreach and small group counseling to reduce HIV risk. About 8,000 men are reached annually and about 1,800 attend workshops. Self-reported rates of unprotected anal intercourse declined after the workshops, from 25.1% to 19.4%, with even greater differences among HIV positive men. (8)

Who is prevention missing?

Ongoing studies show that both HIV prevalence (the proportion of people living with HIV in a population) and risk behaviors remain high among young MSM. In a sample of MSM 15-22 years old in 6 urban counties, CDC researchers found that, overall, between 5% and 8% already were infected with HIV. Higher percentages of African Americans (8-14%) and Hispanics (2-11%) were infected than were whites (2-6%). (10)

MSM of color in the U.S. are disproportionately affected by the HIV epidemic. (11) By March 1993, Latinos comprised 17% of all diagnosed AIDS cases in the U.S., yet represented only 9% of the general population. (12) In Washington, DC, White MSM showed a 16% decrease in AIDS incidence between 1988 and 1993, while African-American MSM showed a 63% increase. (13)

Men who use alcohol or drugs are at a much higher risk for contracting HIV. A recent study of gay men in substance abuse treatment found alarming levels of high-risk sex, levels that approached those recorded before the AIDS epidemic. (14)

Men who have sex with men (MSM) form the largest group of AIDS cases among adults over 50. (15) In the District of Columbia, 11% of the cases of AIDS reported among adult/adolescent MSM of December 31, 1998 were among men 50 or older. (2). Older gay men tend to be invisible and ignored both in the gay community and in prevention. Among the HIV risk factors for older gay men are internalized homophobia, denial of risk, alcohol and other substance use, and anonymous sexual encounters. (16)

What needs to be done?

The scope of HIV among MSM calls for a national effort to reduce new infections. In Canada, the federal government sponsored a simultaneous survey of 4,803 men in 35 cities across the country. Results were published for the public, and based on this, a national intervention project for MSM is being sponsored by the Canadian AIDS Society. (17)

Maintenance of safer practices must be encouraged and examined. Without assistance otherwise, return to unsafe practices should be expected. Service providers and scientists need to study this phenomenon and be prepared to assist those who might or have already relapsed from safer sexual practice either occasionally or altogether. (8)

Better surveillance systems are needed. Vital and important HIV data should be much easier to find. Regular systems of surveillance that keep closer track of changes in the epidemic are needed, so that rapid responses can be mobilized in target groups where the spread of HIV is occurring. (8)

Interventions targeted to "missed" populations are urgently needed. Although programs exist across the country, shamefully few have been evaluated for effectiveness. A comprehensive HIV prevention strategy uses multiple elements to protect as many of those at risk of HIV infection as possible. Continued funding, evaluations, and controlled trials of HIV prevention interventions for diverse groups of MSM must become a priority. (17)

In 1992, a group of AIDS prevention agencies, Department of Public Health AIDS Office staff, concerned prevention professionals and gay men in San Francisco convened to identify the continuing high rates of HIV infection among self-identified gay and bisexual men in that city, and to decide how AIDS prevention efforts can be strengthened to deal with this emergency. Excerpts from their report are found below, on Page 2.28.

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A Call for a New Generation of AIDS Prevention For Gay and Bisexual Men in San Francisco

Excerpted from a report issued by the city of San Francisco, CA, in 1993

Research has documented the reasons gay and bisexual men said they had unsafe sex, including alcohol and drug use, resistance to using condoms, problems with negotiating safe sex, temptation, and pressure from partners difficult to turn down. In 1992, a group of AIDS prevention agencies, Department of Public Health AIDS Office staff, concerned prevention professionals and gay men convened to identify the continuing high rates of HIV infection among self-identified gay and bisexual men in San Francisco and to decide how AIDS prevention efforts could be strengthened to deal with this emergency.

Finding 1:

It is clear that existing models of prevention alone cannot address the powerful emotional issues that have developed for gay and bisexual men after twelve years of life in the midst of an unbelievable crisis, issues that determine whether many men can engage in safe sex for the duration of this epidemic and – in most cases – for the remainder of their lives.

These are the feelings and beliefs many men reported in the focus groups as confounding their best efforts to maintain safer sex practices:

- Low self-esteem
- Need for greater intimacy
- Need for a greater sense of community
- A poorly defined sense of their own future and their community's future
- Need to know others care about their lives

- A perception of the "inevitability" of becoming HIV-infected
- Fear of growing older
- Being overwhelmed by loss and grief
- Desire to life fuller sexual lives
- Being confronted by rampant homophobia and racism

Recommendations

- Prevention efforts should use a variety of strategies that increase resolve to survive the epidemic, including building self-esteem, strengthening ties to the community, building a future and creating a stronger identify for the community apart from the epidemic.
- Institutions within the lesbian and gay community and the larger society must recognize that combating homophobia makes a direct contribution to HIV prevention and redouble efforts to address the civil rights issues of gay and bisexual men.

Finding 2:

Gay and bisexual men have different ideas about when the epidemic will end, ranging from a few years to never. What they believe influences their commitment to safe sex and the level of risk they are willing to assume.

Recommendation

New prevention efforts should remind gay and bisexual men of the realities of this disease; help them deal with the likelihood that they must practice safer sex for the rest of their lives; and help them to cope no matter how long AIDS remains a threat.

Finding 3:

Many gay and bisexual men need to feel that others care about their lives and support their efforts to maintain safe sex. For some men the need to belong and feel valued outweighs the need to remain HIV negative.

Some men who have recently become HIV-positive reported feeling more social support than they did as HIV-negative men. HIV-positive men report a kind of support where previously they faced socially sanctioned homophobia.

Recommendation

A community-wide commitment must be developed to find creative ways to expand and develop social structures to support gay and bisexual men working to maintain safer sex. The community should find ways to help gay and bisexual men who would benefit from involvement in organizations and activities that create a sense of belonging and a sense that others care about their lives.

Finding 4:

In a culture that fear aging and worships youthful appearance, surviving to old age does not appear to be a positive inducement for having safe sex. In addition, men over 35 have seen their support systems and friendship networks decimated by the epidemic. Many are sole survivors among those with whom they came out and looked forward to building a future.

Recommendations

Fears and concerns about aging are particularly crucial for the gay and bisexual men's community to address because they often influence decisions about safe sex. To the extent that gay and bisexual men learn to place greater value on age and aging, they will have greater reason for practicing safe sex.

AIDS prevention images that depict only younger gay men make some older gay men feel their lives are somehow less important. Prevention campaigns should attempt to target portions of their efforts to men of all ages.

Finding 5:

Gay men are generally well informed about what constitutes safe and unsafe sex and most intend to practice safe sex at all times. But some men find themselves unable to say "no" to unsafe sex, for emotional and social reasons, and sometimes out of economic need. Many men in focus groups expressed wariness with having to take responsibility for others.

Recommendation

AIDS prevention efforts must reinforce a sense of responsibility among gay and bisexual men, and help them realize that they always have control over the kind of sex they have and that others ask of them.

Finding 6:

Gay and bisexual men in the focus groups shared remarkably similar emotional issues, crossing all ages, ethnicities and HIV status.

Recommendation

Prevention agencies should coordinate a major effort to address the issues described in this report; combining strategies and resources could significantly enhance the goal of saving lives.

Finding 7:

After seeing safe sex advertising for 12 years, the focus groups revealed that gay and bisexual men can easily tune out these messages. At the same time, gay and bisexual men come from all over to begin new lives, including young men who may have seen little or no prevention material and need basic information and reinforcements about safe sex, and older men who are not accustomed to an urban gay lifestyle.

Recommendations

Prevention agencies should continue to widely distribute thorough messages about safe sex, including the most basic information, but they should also find new and innovative methods to once again capture the attention of their audience.

Coordination among prevention agencies, pressing consistent and complimentary messages, could make safe sex messages more effective and once again unavoidable for gay and bisexual men.

Finding 8:

Gay and bisexual men reported in focus groups that they are confused by differing messages addressing the safety and advisability of oral sex, and want clearer guidance.

Recommendation

If those regarded as experts as seen as confused, safe sex advice becomes far less meaningful. Prevention efforts should be coordinated to assure that advise about oral sex is nor contradictory.

African-American Gay/Bisexual Men

Homosexually active African-American men are over-represented among AIDS cases, even within the gay male population. (1) In the District of Columbia, Black men who have sex with men (MSM) account for 52% of AIDS cases among adult/adolescent black men, and for 30% of all AIDS cases. (2)

The US Census Bureau estimates the adult/adolescent black male population of the District of Columbia at 115,741 as of 1997. Of these, an estimated 10% (11,574) are gay or bisexual males.

While high HIV seroincidence has been documented among homosexual African-American men, behavioral research has rarely studied the HIV risk issues confronting these men. (3) A 1999 study of Black and white MSM in Milwaukee found that African-American men who have sex with men were more likely to be HIV+, to report past treatment for gonorrhea and syphilis, and to have a recent unprotected sex partner known or believed to be HIV+. (1)

The study also found that African-American MSM were less open about their sexual orientation, scored lower in HIV risk behavior knowledge, had more female sexual partners, and more frequently used cocaine in association with sex relative to white men who have sex with men.

In a 1998 survey of more than 7,000 gay, bisexual and homosexually active men by New York City's Gay Men's Health Crisis (GMHC), 13% of the men said they were HIV+, 73% said they were HIV-, and 13% didn't know. Black men had the highest HIV+ rates (17%) followed by Latinos (15%), whites (13%) and Asian and Pacific Islander men (2%), confirming earlier reports that Black and Latino gay men are the hardest hit by HIV. (4) Asian/Pacific Islander men were less likely to have been tested than other races/ethnicities, as were men under 24 and men 60 and over.

In Los Angeles, 29% of the African-American MSM in a 1993 study reported unprotected receptive anal sex and 34% reported unprotected insertive anal sex. Engaging in unprotected anal sex was significantly related to less annual income and education, unskilled labor occupations, presence of relationship partner, less AIDS knowledge, greater number of recent sex partners, and not living in an AIDS epicenter. According to the authors, the results, "highlight the importance of social class and geography as an influential factor in occurrence of extremely high risk sexual behaviors among homosexually active African-American men." (1)

The Young Men's Survey, an ongoing study of young MSM in seven cities (Baltimore, Miami, Dallas, Oakland, Los Angeles, San Francisco and San Jose, California) found that 13% of African-American young MSM were HIV+, compared with non-African-American young

MSM. (5) In New York City, the study found that 18% of young African-American MSM were HIV+, compared 9% of Hispanics and 3% of whites. (6)

In the seven city survey of 15- to 22-year-old MSM, which is funded by the Center for Disease Control and Prevention, 22% of the of the African-American MSM reported unprotected receptive anal intercourse in the previous six months, versus 32% of non-African-American young MSM. A preliminary analysis found two predictors of unprotected receptive anal intercourse: perception of high risk for becoming HIV+ or infecting others, and finding it difficult to practice safer sex. (5)

Participants in a focus group for gay and bisexual African-American men, held in the District of Columbia in August 1998, gave several reasons why individuals engage in risky sexual behavior, including a perception of low risk of HIV infection; clouded judgement from substance use; low self-esteem. Participants also felt that "many" young men were not using condoms because they did not have many friends who had become ill with AIDS, or they felt invincible and/or invulnerable. (7)

There was a strong consensus that prevention services in the District of Columbia are ineffective and not geared to Black gay men. There was frustration that messages on HIV/AIDS prevention were slow to reach the Black community. The group asked for more prevention programs and media advertisements geared specifically to Black gay men, and the inclusion of AIDS education in community activities and events. (7)

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Asian & Pacific-Islander Gay/Bisexual Men

While the number of reported AIDS cases among Asian and Pacific Islander (A&PIs) remains small – about 1% of total cases reported in the U.S. (1), underreporting and a lack of detailed HIV surveillance about A&PIs may mask the true nature of the epidemic among A&PIs. Only the states of California, Hawaii and New Mexico, local health departments in Los Angeles, San Francisco, Oakland and New York City and the territory of Guam report AIDS cases among A&PIs by ethnicity/national origin. (2)

Who are A&PIs at risk?

AIDS cases by exposure category among A&PIs can be compared to other racial/ethnic populations. The proportion of men who have sex with men (MSM) to injection drug users (IDUs) with AIDS in A&PI men (75% / 5%) is very similar to White men (76% / 9%) and different from Black (38% / 26%) and Hispanic men (44% / 37%). Among women, 46% of A&PI women report sex with an HIV+ or high risk partner as a risk indicator, compared to 39% for White, 36% for Black, and 46% for Hispanic women. (3)

In the District of Columbia, 31 cases of AIDS had been reported among A&PIs as of December 31, 1998, of whom 27 were MSM. (4) The US Census Bureau estimates the adult/adolescent A&PI male population of the District of Columbia at 5,535 as of 1997. Of these, an estimated 10% (554) are gay or bisexual males.

What puts A&PIs at risk?

Many gay A&PI men do not perceive themselves to be at risk for HIV. For example, a study of gay A&PI men in San Francisco, CA, found that most (57%) of the men practicing anal intercourse used alcohol before intercourse. One fourth (24%) of the men reported unprotected anal intercourse. However, 85% believed they were unlikely to contract HIV and 95% believed they were unlikely to transmit HIV. (5)

In a 199 assessment of the HIV prevention needs of gay A&PIs in the District of Columbia, 50% of the 27 participants in four focus groups reported that they had engaged in anal sex over the previous six months. Of these, 33% said they never used condoms for anal sex and another 19% said they only used condoms "sometimes." (6) Seventy-four percent of the participants said they never used a condom for oral sex.

Decisions made in "the heat of the moment," impaired decision making due to the use of alcohol, and long term relationships in which they developed trust in their partners were given as reasons why condoms were not used. Low self-esteem, shame and guilt were also mentioned as reasons why individuals engage in risky behavior. (6)

What are barriers to prevention?

There are cultural, linguistic, economic and legal barriers to HIV prevention among A&PIs. For example, cultural avoidance of discussing issues of sexual behavior, illness and death can be barriers to HIV prevention. In addition, although A&PI MSM are at significant risk for HIV, the lack of peer and community support for sexual and racial diversity often are barriers to self-esteem and positive self-identity. (7)

What's being done?

Effective HIV prevention and education programs for A&PIs can use many culturally appropriate strategies. For marginalized A&PI populations such as A&PI gay men, peer-based programs are important. Interventions that include the development of nonverbal and other more indirect communication skills also are more culturally appropriate. Outreach activities can be conducted at cultural events, bars, churches and temples, beauty parlors and massage parlors. (8)

One prevention program in San Francisco, CA used culturally tailored brief group counseling to reduce HIV risk among A&PI MSM. The project fostered positive ethnic and sexual identities by addressing topics such as having dual identities, community, racism and homophobia, and practiced eroticizing and negotiating safer sex. Men who participated became more knowledgeable and more concerned about HIV infection, and reported fewer sexual partners. Chinese and Filipino men reported reductions in unprotected anal intercourse. (9)

Participants in the DC study identified several issues that should be included in prevention programs for gay A&PIs, including workshops on risk assessment, safer-sex negotiating skills, and self-esteem. (6) The report on this study also identified a need for "culturally sensitive coming out tools and/or resources that will address the issues of being queer alongside cultural issues about being Asian or Pacific Islander."

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Hispanic/Latino Gay/Bisexual Men

Hispanic/Latino men account for 3% of all AIDS cases among adult/adolescent men in the District of Columbia, and for 5% of cases among men who have sex with men (MSM). (1) Of the 319 cases of AIDS reported among Hispanic/Latino men, 72% were attributed to MSM, 9% to heterosexual contact and 8% to injection drug use. The rate for MSM is higher than for Black men (52%) but lower than the rate for white men (91%).

The US Census Bureau estimates the adult/adolescent Hispanic/Latino male population of the District of Columbia at 15,650 as of 1997. Of these, an estimated 10% (1,568) are gay or bisexual males.

An assessment of the HIV prevention needs of gay/bisexual Hispanic/Latino men in the District of Columbia, performed in 1996, found that while there was a high level of knowledge about how HIV is transmitted and most individuals knew what to do to reduce the risk of HIV transmission, individuals did not always recognize high risk behavior when they engaged in it. (2) This finding was echoed by a participant in a DC focus group for gay/bisexual Hispanic/Latino men, held in August 1998, who stated: "People know what to do to protect themselves, they just do not do it."(3)

Forty-six percent of study participants indicated that they engaged in anal sex, and of those that engaged in anal sex approximately 25% did not use a condom every time. (2)

Self-perception of risk in this population was not measured by the risk of the behavior, but by an individual's perception of his prospective partner's serostatus. Those that did not use condoms every time cited the influence of their sexual partner as the most common reason for this failure.

Participants in the focus group identified cultural characteristics in the Latino gay community that may be barriers to safe sex practices and the dissemination of prevention information. The men perceived the Hispanic/Latino gay community to be "closed." Gay "lifestyle," particularly sex, is not openly discussed, and most safe sex information seems to filter in from the heterosexual information that is out on the street. (3)

Behavioral studies done to date converge on the finding that Hispanic/Latino gay/bisexual men have had enormous difficulties adjusting to condom use and adopting less risky forms of sexual behavior. (4) Five studies that have measured rates of unprotected anal intercourse in gay/bisexual men show that Hispanics/Latinos had the highest rates of unprotected anal intercourse when compared to samples of non-Latino Whites, African-Americans, or men from other minority groups.

Of special concern is that risk behavior occurs in the presence of substantial knowledge about modes of HIV transmission and means of prevention, as well as in the presence of relatively strong intentions to practice safer sex. (4) The situation is further complicated by the frequent use of drugs/alcohol during sex, increased anonymous encounters in public sex environments, and situations of financial dependence leading to prostitution and/or sexual relations with men of unequal power and status.

Research suggests that sexual self-regulation among Latino gay men is jeopardized by a host of complex socio-cultural factors — such as machismo, homophobia, sexual silence, family disruption, poverty and racism — that contribute to decreased self-esteem, perceptions of low

sexual control, a sense of social isolation, and fatalism regarding the inevitability of HIV infection. (4)

In a New York city study that made a systematic examination of HIV risk behaviors and barriers to condom use among Puerto Rican MSM, participants reported significant barriers to condom use in several areas: dislike of condoms and/or concern about diminished pleasure (60% of participants); low risk perception (46%); trust in and emotional connection with partner (42%); unavailability and/or inconvenience of condoms (31%); lack of control related to passion, excitement, impulsivity, or substance use (25%); indifference and/or ignorance about safer sex (16%); and communication problems and/or omission (13%). (5)

The study also revealed a significant association between history of childhood sexual abuse and increased likelihood of engaging in HIV-risk sexual behaviors. One third of the sample reported having had sexual contact before the age of 13 with someone at least four years older. Half had felt physically or psychologically hurt by the experience and were considered to be abused for this study. Abused men were more likely to engage in unprotected receptive anal sex in adulthood than men who had not had sex (prior to age 13) with an older partner. Those respondents who had not felt hurt by the experience fell between the abused and no-older-partner groups. (5)

Three other studies with Hispanic/Latino MSM have described many traumatic experiences in their lives, including heavy stigmatization, harassment, discrimination, violence, and even childhood sexual abuse, which may result in feelings of disempowerment and low critical consciousness, the desire for immediate gratification and the presence of self-justifications that interfere with consistent safer-sex behavior. (5)

The preliminary results of the Latin American Men Study show that between 40% and 50% of Hispanic/Latino MSM practicing anal intercourse use condoms inconsistently or not at all. (5)

A New York study of HIV+ men of Latin American found that about half of the men had engaged in unprotected anal sex during the year prior to the assessment. The occurrence of unprotected anal sex appeared unrelated to the respondents' age, education, income, time spent in the US, acculturation, childhood sexual abuse history, condom skills, involvement in commercial sex, time elapsed since finding HIV-positivity, presence of AIDS diagnosis, partner type (lover, one-night-stand or other), or having an HIV-negative partner. (6) Nor was unprotected anal sex associated with the psychological constructs of machismo, or sensation seeking.

Compared to HIV-positive men who did not practice unprotected anal sex, HIV-positive men who did it experienced more pleasure without condoms than with condoms, held more negative attitudes about condoms, believed that under certain conditions unprotected anal sex is less risky, were less certain about their ability to consistently avoid unprotected anal sex (self-efficacy), and felt less pressure from lovers or friends to always use condoms.

The Salud needs assessment found a need for prevention interventions that address the self-perception of risk, self-esteem, self-worth, relapse prevention and negotiation skills. Individuals need to have a more concrete idea of how to measure their own individual risk and what steps to take to avoid that risk. This must be carried out through comprehensive interventions that raise the issues of sexual behavior and risk individually. At the same time, the intervention must provide skills to address self-esteem and self-efficacy of participants, so they can effectively take those steps necessary to reduce their level of risk. (2)

The study also found a need for innovative efforts to reach the population. The length of time and the different methods that had to be used to recruit participants for the assessment demonstrated the difficulties in reaching this population. Recruitment through fliers and newspaper advertisements was not effective in accessing the population and street outreach was only moderately successful at one location where gay and bisexual Latino men congregate. Any interventions must be grounded in and have extensive contacts within the community, and include active participation of the stakeholders in the community, in particular community activists.

Surveys respondents and most participants in a community forum also indicated most they did not know what types of resources are available to learn about HIV prevention. Although most respondents indicated that they are very concerned about HIV, they could not describe any institutional source they accessed to obtain information. They also stressed a lack of continuity in community-related activities. Several organizations that have provided programs for this community have either ceased to exist or have not continued their activities at the same level, leaving the community with a sense that they have no place to turn to for support for themselves or their friends.

Participants in the DC focus group for gay/bisexual Hispanic/Latino men identified a need for prevention information in Spanish, as well as more outreach activity in Spanish-speaking neighborhoods, and the establishment of networks and opportunities to socialize beyond bars and similar establishments.

One finding of the Latin American Men Study is that there appears to be enough similarities among groups of different national origin to justify a common HIV-prevention strategy for Hispanic/Latino MSM. Issues such as language dominance, immigration status, and unemployment are likely to be more relevant to the design of a prevention program than the national ancestries of various Latino MSM. (5)

New York City's Empowerment program for Hispanic/Latino MSM provides eight sessions that focus on critical experiences likely to have occurred to this population, eliciting personal associations, promoting critical analysis about the consequences that such experiences had in the life of the participants, and discussing their feelings of disempowerment. This is followed by a period of collective problem solving to find alternative, more empowering ways to deal with everyday demands, including safer sex behavior. The process is facilitated, but not prescribed, by an activist or educator. (5)

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White Gay/Bisexual Men

Of the 326,051 cases of AIDS among adult/adolescent men who have sex with men (MSM) reported in the U.S. as of December 31, 1998, 64% were among white men. (1) But the estimated number of AIDS diagnoses each year (AIDS incidence) among white MSM has been declining since 1993, reflecting in part the success of prevention programs in these communities. (2)

In the District of Columbia, MSM account for 91% of AIDS cases among adult/adolescent men as of December 31, 1998, and white MSM account for 37% of all cases of AIDS among adult/adolescent MSM. (3)

The US Census Bureau estimates the adult/adolescent white male population of the District of Columbia at 79,284 as of 1997. Of these, an estimated 10% (7,928) are gay or bisexual males.

In a 1998 survey of more than 7,000 gay, bisexual and homosexually active men by New York City's Gay Men's Health Crisis (GMHC), 13% of the men said they were HIV+, 73% said they were HIV-, and 13% didn't know. (4) A 1998 study conducted by the New York City Department of Health found that 12% of a sample of 15 to 22 year old MSM were infected with HIV. The percentage was even higher for young African American MSM (18%) and mixed race MSM (16%). For young Hispanic MSM the rate was 9%, while for young white MSM it was 3%. (5)

Participants in a DC focus group with white gay men, held in August 1998, expressed concern that the white gay community has been inundated with HIV prevention messages and is now adept at tuning out those messages. Men may not identify with risks and are no longer feeling vulnerable. (6)

It was emphasized again and again throughout the session that effective prevention efforts for this community must be broad and multi-faceted in order to motivate changes in risky behavior. A single campaign needs to incorporate a variety of messages for different sub-populations and use a variety of media in distributing those prevention messages. (6)

Participants said targeted intervention for this population must be positive, emphasize self-esteem and self-efficacy, and avoid the "condescension and preachiness that has characterized many efforts in the community."

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Young Gay and Bisexual Men

Ongoing studies show that both HIV prevalence (the proportion of people living with HIV in a population) and risk behaviors remain high among young gay and bisexual men. (1)

- In a sample of MSM 15-22 years old in 6 urban counties, CDC researchers found that, overall, between 5% and 8% already were infected with HIV. Higher percentages of African Americans (8-14%) and Hispanics (2-11%) were infected than were whites (2-6%).
- Only about half of U.S. states conduct HIV surveillance, but in these states, data show that substantial numbers of men who have sex with men (MSM) are still being infected, especially younger men. In 1997, 47% of HIV diagnoses among adolescent males aged 13-19 and 53% of cases among men aged 20-24 were attributed to male-to-male sexual contact. There are no HIV surveillance studies among young gay and bisexual men in the District of Columbia.

In the District of Columbia, MSM accounted for 52% of all adult/adolescent AIDS cases reported as of December 31, 1998. Of the 312 cases reported among young males – between the ages of 13 and 24 – 67% were among MSM.

The US Census Bureau estimates the adult/adolescent male population of the District of Columbia (ages 15 to 24) at 28,038 as of 1997. Of these, an estimated 10% (2,804) are gay or bisexual males.

Young MSM accounted for 3.6 percent of all MSM cases. (2) The District does not collect data on HIV infections, but recent studies among young gay men in several US cities have shown high rates of HIV infection.

Because of the long and variable time between HIV infection and AIDS, surveillance of HIV infection provides a much clearer picture of the impact of the epidemic in young people than surveillance of AIDS cases. A study that analyzed data from 25 states that had integrated HIV and AIDS reporting systems for the period between January 1994 and June 1997 found that young people (aged 13 to 24) accounted for a much greater proportion of HIV than AIDS cases (14% versus 3%). Nearly half (44%) of the HIV infections in that age group were reported among young females, and well over half (63%) were among African-Americans. (5)

A 1998 study conducted by the New York City Department of Health found that 12% of a sample of 15 to 22 year old MSM were infected with HIV. The percentage was even higher for

young African American MSM (18%) and mixed race MSM (16%). For young Hispanic MSM the rate was 9%, while for young white MSM it was 3%. (3)

The study – which interviewed 545 MSM ages 15 to 22 – also found that a 46% of young MSM reported that they recently had unprotected anal sex. The Young Men's Survey-New York City is one of a series of studies in nine urban areas funded by the CDC, and preliminary reports suggest that these are nationwide trends.

The study concluded that a substantial proportion engaged in high risk sex and sex with older partners and that many of the people who tested positive for HIV were infected within the previous two years.

A 1998 study of 425 gay men aged 17 to 22 in San Francisco found an HIV prevalence rate of 9.4%. Dennis Osmond of the Center for AIDS Prevention Studies at the University of California at San Francisco (CAPS) estimated that by the time these men reach their 40s and 50s 20% to 30% of them will be infected with HIV. (6)

For young African American men the rate was 21.2%, according to CAPS researcher Maria Ekstrand. In a 1996 study by Ekstrand, among gay and bisexual men 18 to 29, 51% of the respondents said they had engaged in unprotected anal intercourse. About half of these men also said they were doing it with partners whose HIV infection status they did not know or whose status, if known, was different from theirs. (6)

A study by the Centers for Disease Control and Prevention showed that young gay men in the United States are more likely to practice unsafe sex and contract HIV as compared to their older counterparts. The study, presented by Dr. Gordon Mansergh at the 12th World AIDS Conference in Geneva, investigated sexual habits among HIV-negative gay and bisexual men in Denver, Chicago, and San Francisco. Almost two-thirds of the gay men reported that they had engaged in unprotected anal sex in the previous 18 months and 56 percent of gay men aged under 25 years said that they had engaged in unprotected receptive anal intercourse in the same time frame. Comparatively, 46 percent of older gay men reported that they had engaged in the same risky activity in the prior 18 months. The study found that the increased risk habits are associated with perceived peer norms concerning unprotected anal sex. Additionally, young gay men who socialize and meet partners in bars were more likely to have unprotected sex. The researchers suggested that prevention efforts focus on changing peer norms and reaching young men in bar settings. (4)

What places young gay men at risk?

In contrast to studies with older gay men, which demonstrate dramatic reductions in HIV risk-taking behaviors, (6,7) a variety of studies show that young gay men are engaging in high rates of unsafe sex. In a survey of gay men aged 18-25 in three medium-sized West Coast communities, 43% of the sample reported having engaged in unprotected anal intercourse during the previous 6 months. (8) A study of gay and bisexual adolescent males in Minnesota found that 63% were at "extreme risk" due to unprotected anal intercourse or intravenous drug use. (9) A San Francisco telephone survey showed that 44% of gay men under the age of 30 had engaged in unprotected anal intercourse during the previous year, compared to 18% of the men over age 30. (10)

The majority of participants in a District of Columbia focus group with young African-American gay men (between 13 and 24), held in May 1999, said they knew how HIV is

transmitted. But when asked if they discussed the HIV status of themselves or their potential sexual partners before engaging in sexual relations, more than half of the nine participants said they did not. In addition, one third of the participants said that if their potential partners said they were HIV- they would be inclined to take higher risks than if they were told the potential partner was HIV+.

A complex array of factors - at individual, interpersonal and community levels - contributes to the high sexual risk-taking of young gay men. Since the bulk of AIDS cases among gay men is among men aged 30-40, many young gay men perceive AIDS as a disease of older men and feel it is safe to have unprotected sex with other young men. Most young men know how HIV is transmitted and men who engage in unprotected sex do label their behavior as putting themselves at risk for AIDS. Nonetheless, with their feelings of invulnerability typical of youth, young men may feel the negative consequences "won't happen to me". (8)

Young men are often in an exploratory phase with regard to sexuality, which may entail high numbers of partners and a willingness to try a variety of activities. Due to inexperience, young men may be less competent in negotiating low-risk sex and less knowledgeable about making safe sex activities enjoyable. Coming out as gay can also be a period of great emotional turbulence, resulting in low self-esteem and depression, which may reduce their feelings of self-efficacy and motivation for safe sex. (11)

Further, protecting one's health is not necessarily a young gay man's main concern. Interpersonal motivations may be more pressing - wanting to fit in, to find companionship and intimacy. However, interpersonal issues can also contribute to unsafe sex. For young gay men, unsafe sex is most likely to occur with a boyfriend – someone whose affection is very important to them. (8)

The social structure and norms of the young gay subculture may not be entirely conducive to safer sex. In many communities, gay bars and public cruising settings provide the main opportunities for young gay men to meet and socialize. Yet each is highly sex-charged and the bar scene's emphasis on alcohol sets the stage for engaging in sex while high - consistently found to contribute to unsafe sex. (12)

A San Francisco study that examined the relationships between self-acceptance of gay identity, sexual risk-taking behavior and mental health in gay men aged 18-27suggests that HIV prevention interventions for young gay men can be more effective if they facilitate personal and cultural environments that increase self-acceptance. (14) The study found that self-acceptance of gay identity predicts increased psychological health, sexual orientation disclosure, and decreased sexual risk behavior.

The study also found that gay community involvement predicts social support for and self-acceptance of gay identity; that social support for gay identity is related to self-acceptance of gay identity and psychological health; and that men who accept their sexuality most are also likely to be more psychologically healthy.

What works for young gay men?

While the number of AIDS cases is declining, the number of MSM living with HIV infection is growing. This increased prevalence of HIV in the population means that even more prevention efforts are needed. (1)

Since there are multiple factors that contribute to HIV risk-taking among young gay men, multi-level prevention programs are necessary - programs that impact variables at individual, interpersonal and social system levels. New young men will come out each year who have not been exposed to prevention campaigns of previous years, thus HIV prevention for young gay men must be ongoing and dynamic. (12)

Engaging, creative programs are needed that address HIV prevention within the contexts of young gay men's lives, incorporating issues of self-esteem, coming out, substance use and interpersonal and social needs. Community-level and peer outreach programs are especially promising, and services for young gay men of color are particularly needed. Since previous sexual history is a strong predictor of current risk-taking behavior, intervention at an early point in a young man's sexual initiation will be maximally effective. (10)

The involvement of community and opinion leaders in prevention efforts will be critical to overcome cultural barriers to prevention, including homophobia, (6) which may discourage young gay men from accessing prevention services. (12) For example, there remains a tremendous stigma to acknowledging gay and bisexual activity in African-American and Hispanic communities. (6)

A study done in California found that, "to be effective, HIV prevention programs must respect the complex, multi-determined nature of sex for young gay men and understand their personal meanings of sex." Seventy two percent of the participants in the study felt they engaged in sex with other men because of the physical pleasures of sex, but the interpersonal roles of sex were also important. They used sex as a way to express affection (46%) and as a relationship-building tool (33%), i.e., to get to know someone, make friends or test the potential for a relationship. Sex also served important psychological functions, i.e., alleviating loneliness (25%), boosting self-esteem/validating one's desirability (23%). (13)

Frequently cited reasons for unsafe sex were: assuming the partner was "safe", i.e., HIV- or monogamous (39%), influence of drugs/alcohol (37%), physical enjoyment (24%), feeling invulnerable (22%), losing control in the "heat of moment" (20%), non-assertiveness (16%), desire to please partner (12%), pressure from partner (10%), curiosity (10%), and no condoms available (10%). Most men knew their behavior was risky for HIV, but felt their personal needs had overwhelmed their health concerns.

The study's authors concluded that, "Helping men to identify their reasons for having sex in particular situations, explore alternative means of filling those needs and/or empower them to have sex safely may prove valuable. Focusing on the disease transmissibility of sex should not overshadow an appreciation of the important interpersonal and psychological roles sex serves for young gay men. "

According to Maria Ekstrand, of the Center for AIDS Prevention Studies, HIV prevention programs for gay and bisexual youth must address many special concerns, including:

- Many young gay men perceive AIDS as a disease of older men and feel it is safe to have unprotected sex with other young men.
- Young gay men are more inexperienced and may be less competent in negotiating low-risk sex.

- Coming out as gay can be a period of great emotional turbulence, resulting in low self-esteem and depression, sometimes reducing motivation for safe sex.
- Young gay men may be more interested in being accepted by their peers and finding companionship than in protecting their own health. For young gay men, unsafe sex is most likely to occur with a boyfriend – someone whose affection is very important to them.

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Heterosexual Men

New AIDS cases are increasing most rapidly among people who were infected through injection drug use (IDU) and heterosexual contact. (1) The rise in IDU infections in heterosexual men has lead to the rise in heterosexual infections in women, as more women become infected from men who are IDUs. For this reason, sexual behavior change among heterosexual men will be key to controlling the HIV epidemic for heterosexual men, women and children.

In the District of Columbia, 6% of the AIDS cases reported among adult/adolescent males as of December 31, 1998 were among men whose risk factor was heterosexual sexual relations. (2) Most of the cases, 89%, were among Black men.

What puts men at risk?

Many HIV prevention programs in the U.S have addressed the drug-using risks of heterosexual men, but few have addressed their sexual behavior risks. In the U.S., women have been the primary focus of sexual behavior change among heterosexuals. This approach fails to take into account gender and power imbalances, and does not encourage men to take responsibility for their own health or the health of their partners and family. (3)

Injection drug use poses the highest risk to heterosexual men. (1) Use of other non- injected substances such as crack cocaine and alcohol can increase sexual risk taking, increasing the risk of HIV infection. A survey of heterosexuals in alcohol treatment programs in San Francisco, CA found HIV infection rates of 3% for men. This was considerably higher than rates of 0.5% found in a general population survey. (4)

Men in certain settings are at greater risk. In the U.S., 90% of prisoners are men. In 1994, AIDS cases for people in State or federal prisons reached 518 for every 100,000, as compared to 41 for every 100,000 for the general population of the U.S. (5) Injection drug use, other illicit drug use and unprotected sex with other men are all risk behaviors for HIV in prison or jail. (3)

A survey of active duty men in the US Army found that heterosexual men who had sex with prostitutes, had increased numbers of female partners, had non-steady partners, or had sex on the first day of acquaintance were at highest risk for HIV infection. (6)

What makes prevention difficult?

Safer sex guidelines can be at odds with some perceived male roles. (7) For example, masculinity and sexuality are sometimes defined by having sex with multiple partners, in contrast to safer sex guidelines that call for reducing numbers of partners. A study of HIV+ male and female heterosexuals found that before diagnosis of positivity, men had far fewer monogamous relationships than women (4% vs. 55%). After diagnosis, none of the women, but 14% of men reported having multiple partners. (8)

Communication between men and women can be difficult, especially regarding condom use, disclosure of risk behaviors or HIV status. Traditional social and cultural gender roles in the U.S. often portray women, and not men, as the "communicator" in relationships, which might serve to relieve men of responsibility for communication. (7) In 1995, over half of all female AIDS cases occurring via heterosexual contact were a result of sex with a male partner whose HIV risk was either unknown or unreported, showing that women are often unaware of their partner's HIV risk. (1)

Male violence and sexual coercion can be a barrier to safer sex. For example, a survey of Latino heterosexual men in the U.S. found that traditional Latino gender role beliefs impede condom use by encouraging sexual coercion, lowering sexual comfort and interfering with self-efficacy to use condoms. (9)

IDUs often lack access to sterile syringes via needle exchange/distribution programs or pharmacy sales. Access to drug treatment programs is also insufficient-at any given time, only 15% of IDUs in the U.S. are in treatment programs. (10)

What would an intervention for heterosexual men look like?

Unfortunately, very few programs exist in the U.S. to address heterosexual male sexual behavior. (3**)** Most prevention efforts aimed at heterosexual male sexual behavior have taken place in developing countries, where the HIV epidemic continues primarily to affect heterosexuals. These have focused on clients of prostitutes, couples counseling, and condom social marketing. Interventions for heterosexual men can use multiple components, including:

Counseling both men and women. A study of discordant heterosexual couples (where one is HIV-infected and the other is not) found that counseling men and women together increased consistent use of condoms. Of the 124 couples who did use condoms consistently for vaginal and anal intercourse, none of the negative partners became infected, despite a total of about 15,000 episodes of intercourse. (11)

Helping men rethink notions of intimacy. Programs can address different male beliefs, and use consciousness raising to address the notion of gender roles and coercive behaviors in men, as well as help men embrace an idea of intimacy that can work in conjunction with HIV prevention. Skills building to increase sexual impulse control can also help men deal with violence and coercion, as well as help reduce number of partners. (9)

Heterosexual male peer education. In addition to couples counseling, programs should provide counseling for and by men alone. Research has found that men are interested in family planning, but may not want to discuss it only with their wives or partners. Peer educators can teach and model effective preventive behaviors in settings where men may gather, such as gyms, barbershops or sporting events. (12)

Helping men communicate with women. Like many people in relationships, heterosexual men may find it difficult to talk about sex and love with their partners. One study of young African-American men, for example, demonstrated that regarding sex, men often say what they think their partner wants to hear. (13) Programs that help increase communication skills can be effective.

Focus on men who have sex with men and women (MSMW). A survey of MSMW found that 54% of their female partners did not know about their homosexual activity, and 65% of the men had engaged in unprotected sex with their female partners. (14) Helping MSMW with communication and disclosure skills, as well as skills for correct and consistent condom use, can be beneficial.

Condom social marketing. In Zaire, careful consumer research produced "Prudence," a condom designed and priced to be culturally sensitive, attractive and affordable. Total sales of Prudence increased 443% from 1988 to 1989, and in many regions of Zaire, the word Prudence has become a generic substitute for the word condom. (15)

What needs to be done?

Focusing HIV prevention efforts on heterosexual male sexual behavior in the U.S. can make a difference in the epidemic among men, their female partners and their offspring. As new AIDS cases are increasing most rapidly through heterosexual contact in the U.S., this new focus will take on even greater importance. Changing male cultural and socialization patterns will certainly not be an easy task, but targeted interventions can be effective. (3)

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HIV has become a major threat in Latino communities, many of which were disadvantaged even prior to HIV due to minority status, economic disparities and language barriers. Latinos in the U.S. are disproportionately affected by HIV, accounting for 17% of total AIDS cases while comprising only 9% of the population. Latino children account for 12% of the population under 13, but 24% of pediatric AIDS cases. (1)

Contrary to the national rent, Hispanics/Latinos are underrepresented in AIDS cases in the District of Columbia. Hispanics/Latinos comprised 7% of the District's population in 1997, but Hispanic/Latinos account for 3% of AIDS cases among adult/adolescent men and 1% of cases among women reported as of December 31, 1998. (2,3)

HIV prevalence among Latinos in the U.S. varies strongly by region. A high rate of HIV exists among Latinos in the Northeast where many Latinos from Puerto Rico and the Dominican Republic live, reflecting the geography of injection drug use in the US. Much lower rates are reported for Latinos in the West/ Southwest, where many Latinos of Mexican and Central/South American origin live. (4)

Forty-three percent of all AIDS cases among Hispanic/Latino adult/adolescent men reported as of December 31, 1998, occurred in men who have sex with men and 36% among injection drug users (IDUs). Heterosexual contact was the risk factor in 7% of the cases.

Among adult/adolescent Hispanic/Latina women, 47% of AIDS cases were due to heterosexual contact and 41% were due to injection drug use. (1) Of the cases attributed to heterosexual contact, more than half involved sex with an injecting drug user.

Among Latino gay/bisexual men, rates of HIV infection are increasing faster than among white gay/bisexual men-a 40% increase for Latinos from March 1993 to June 1994, compared to 29% for whites. (5) These rates are likely underestimates because many Latino men who have sex with men do not self identify as gay/bisexual. (6)

What are the factors for risk?

Latinos in the US are a multi-ethnic and multi-cultural population, representing over 30 geographic regions. HIV risk among Latinos varies depending on level of acculturation, (7) life-style, where they were born, and where they live in the US. (8)

U.S.-born Latinos make up the largest proportion (33 percent) of the total cases among Hispanics/Latinos reported in 1997. Unfortunately ancestry data is not collected for U.S.-born Latinos. For Latinos born outside of the continental U.S., persons born in Puerto Rico bear a disproportionate burden of the AIDS epidemic among Latinos. Of the 12,356 adult cases reported among Hispanics/Latinos in 1997, Puerto Rican-born persons accounted for 27 percent of the cases compared to Mexican-born persons who accounted for 9 percent of the cases. Central/South American-born persons accounted for 6.4 percent and Cuban-born persons accounted for 2.4 percent of the AIDS cases among Hispanic/Latino adults in the same year. (9)

Puerto Rican-born Latinos account for the largest proportion of cases among Hispanic/Latino injecting drug users (IDUs) and Mexican-born Hispanics/Latinos account for the highest cases among men who have sex with men. (9)

The differences between the expectations and attitudes of Latino men and women result in a fairly strong double standard that allows men to have sex outside of marriage. (10) In a telephone survey in nine states with high proportions of Latinos, we found that twice as many married Latino men reported multiple sexual partners in the previous year as did non-Latino white married men (18 versus 9 percent, respectively). (11) In addition, 60 percent of unmarried Latino men reported multiple sexual partners in the 12 months prior to the interview. Thus, many monogamous Latino women could be at risk from their partner's behavior. (10)

A number of studies reported that Latinos have less information about HIV disease and HIV transmission than do other groups. (12,13)

Latinos who inject drugs are infected with HIV or are diagnosed with AIDS at higher rates than are non-Latino whites who use drugs. (14) Differences in drug use patterns may account for this. One study of IDUs found that Latinos had higher frequencies of injection drug use (Latino drug users inject more frequently than do non-Latinos per month) and were more likely to inject in shooting galleries (places where drug users rent used syringes and needles). (15)

Cultural influences such as machismo, familismo and homophobia may be internalized by Latino gay men and make safer sex practices difficult. Machismo dictates that intercourse is a way to prove masculinity. For gay Latinos, familismo can create conflict because families perceive homosexuality as sinful. Familial support is often achieved through silence about sexual preference, instilling low self-esteem and personal shame among Latino gay men. (16)

Among Latinos, Puerto Ricans have the highest prevalence of illegal drug use. This may be partially explained by the fact that 70% of Puerto Ricans living in the US live in New York City, New Jersey and Chicago, where rates of poverty are higher and the availability of illegal drugs is higher than in other parts of the country. (17)

What are barriers to prevention?

Traditional interpretations of cultural values and gender roles may be barriers to maintaining safer sex practices for many Latino women. In a survey, 67% of Latino women reported never using condoms with their steady partner. In a traditionally machista society, women often do not talk to men about sex because it suggests promiscuity, and frequency and type of sex is most often determined by men. (18)

A strong relationship exists between cultural and societal homophobia and HIV risk. A study of Mexican gay/bisexual men in Juarez, a Mexico/US border town, found that unsafe sex was significantly higher among older men, factory workers, men who preferred anonymous partners, and men with a history of at least one STD. These men may be unwilling to confront societal attitudes and prejudice around homosexuality. (19)

What can help in prevention?

Greater understanding of and respect for Latino cultures will lead to better HIV prevention efforts. Prevention programs for Latinos must take into account cultural characteristics including familismo, simpatía, and personalismo. (20)

- Familismo, or the importance of the family as a social unit and source of support, can be a barrier to educators, with whom Latino clients may not share their concerns. On the positive side, it can be a powerful factor to motivate behavior change.

- Simpatía refers to the importance of polite social relations that shun assertiveness, negative responses and criticism. Educators need to be aware that Latinos may appear to agree with a message that they may not understand or intend to follow.

- Personalismo refers to the preference for relationships that reflect familiarity and warmth. HIV information and service delivery is most effective when workers establish warm relationships and ask questions about family and shared experiences.

For HIV prevention to make a difference, Latinos must attempt to break the silence about sexuality in their communities, address homophobia, and address specific cultural aspects that may be detrimental to healthy sexuality, such as not allowing power for women, and encouraging men to prove their masculinity through intercourse. (21)

What's being done?

Few prevention programs addressing Latinos have been evaluated, and effective behavior change models are still being developed. However, promising programs incorporate extensive preliminary work in targeted Latino populations, (4) use Latino peer educators, stress empowerment and self-esteem building, and expand beyond issues of HIV to incorporate broader issues of relationships, family, and culture.

Porque Sí, an AIDS education video developed for and tested by Latinos, was used at an STD clinic in the South Bronx, NY. Some clients at the clinic were offered the video, or video and interactive group session, as well as coupons for free condoms. Latino clients who saw the video and participated in group sessions were almost twice as likely to redeem coupons as clients who did neither. (22)

Hermanos de Luna y Sol, an ongoing intervention for Latino gay/bisexual men in San Francisco, CA, attracts clients by appealing to brotherhood and the family of gay men. The first group session deals with the common history of oppression among Latino gay men, including issues of homophobia, machismo, sexual abuse, racism and separation from family and culture. AIDS and sexuality are then discussed in the second session. (5)

An AIDS prevention program for Latino youth in Boston, MA, used Latino peer leaders to help teens reduce unprotected sex. They held workshops in schools, community organizations, health centers and in teens' homes, and distributed kits with condoms and instructions. The program did not increase sexual activity for the teens; males were less likely to start sexual activity and females less likely to have multiple partners. (23)

What still needs to be done?

Very few evaluated prevention programs have targeted Latino drug users or men who have sex with men, the two groups most affected by HIV. Programs for heterosexual couples should target both partners, and women should receive routine prenatal HIV counseling and voluntary testing. Prevention programs need to address these populations with Latino-only studies. Many studies include multi-ethnic populations, making it hard to identify Latino-specific findings. (4)

The social and political climate in the US today poses serious problems for effective HIV prevention in Latino communities. (21) Policy on immigration and mandatory HIV testing contribute to an environment of powerlessness and discrimination. Latinos, like many communities greatly affected by AIDS, need greater access to education, health care and social benefits.

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Hispanic/Latino Men

Hispanic/Latino men represent 8% of all men in the District of Columbia (1), but account for only 3% of all AIDS cases among adult/adolescent men. (2) Of the 319 cases of AIDS among adult/adolescent Hispanic/Latin men reported as of December 31, 1998, 72% were attributed to sex with other men, higher than the rate for Black men (52%) but lower than the rate for white men (91%). Eight percent of the cases among Hispanic/Latino 8% to injection drug use and 7% to heterosexual contact.

Traditional gender role beliefs – which reinforce images of dominant men and submissive women – impede condom use among Hispanics/Latinos, according to a 1996 national study of condom use. (3) Men are encouraged to use sexual coercion, and have lower sexual comfort and self-efficacy to use condoms. Hispanics/Latinos report significantly higher levels of sexual discomfort than do non-Latino whites (4), which is often associated with higher-risk sexual behavior.

One in five Hispanic/Latina women in the study reported a history of sexual abuse and/or rape in their lifetime. Of Hispanic/Latino women who had sex with a man in the previous year, 73% reported their partner insisted on having sex when they were not interested, 23% report being yelled at, 3% report being hit and 14% report being harmed in some other way during sex. Among Hispanic/Latino men, 68% report that in the past year they have insisted on having sex with a female partner, 30% lied to convince her to have sex, and 51% said she initially resisted, but then changed her mind. (3)

Both men and women reported similar levels of condom use: 34% always use condoms with their steady partner, 70% use condoms the first time they had sex with their most recent partner, and for those with multiple partners in the last twelve months, 47% always used condoms with all partners. Both men and women who hold more traditional gender norms are less likely to use condoms. (3)

Sexuality appears to be even more intensely private and personal in Hispanic/Latino culture than in non-Latino white culture. (5) In traditional Hispanic/Latino culture, the "good" woman is not supposed to know about sex, so it is inappropriate for her to bring up subjects like HIV disease and condoms. (6,7) Recent open-ended interviews suggested that unmarried Latino women fear a man will label them "fast" if they suggest using a condom. At the same time, Hispanic/Latino men may assume no condom is needed if the woman does not suggest it. (5)

The authors recommend that HIV prevention interventions to increase condom in this population include consciousness raising designed to address gender role beliefs and coercive behaviors in men, promote equal decision-making, and provide skills building to increase men's sexual impulse control and self-efficacy to use condoms. (3)

In a study of HIV risk behaviors among Hispanic/Latino men with mental illness in a New York City homeless shelter, 60% of the men reported unprotected episodes with female partners and 57% with male partners. Most sexually active men reported having had sex with multiple partners: 67% of the 45 who had sex with women and 67% of the 9 who had sex with men. In addition, half of the 80 men interviewed reported lifetime histories of crack-cocaine use and 34% reported histories of heroin use. (7)

The high rate of multiple sexual partners and life-time heroin use, within the context of a documented HIV prevalence of 26% in this population, make these men an especially high risk group for sexual transmission and contraction of the infection. (7)

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Hispanic/Latina Women

Hispanic/Latina women represent 6% of all women in the District of Columbia (1), but account for only 1.2% of all AIDS cases among adult/adolescent women. (2). Of the 23 cases of AIDS among adult/adolescent Hispanic/Latina women reported as of December 31, 1998, 78% were contracted through heterosexual contact and 22% were attributed to unknown or other risk factors. No cases were attributed to injection drug use, which accounts for 56% of all cases among women, including 57% of cases among Black women and 53% of cases among white women.

Traditional gender role beliefs – which reinforce images of dominant men and submissive women – impede condom use among Hispanics/Latinos, according to a 1996 national study of condom use. (3) Men are encouraged to use sexual coercion, and have lower sexual comfort and self-efficacy to use condoms. Hispanic/Latina Women who reported higher levels of sexual disempowerment reported significantly lower levels of sexual comfort and lower peer norms, which are strongly related to condom negotiation self-efficacy among Hispanics/Latinos.

Hispanics/Latinos report significantly higher levels of sexual discomfort than do non-Hispanic/Latino whites (4), which is often associated with higher-risk sexual behavior.

One in five Hispanic/Latina women in the study reported a history of sexual abuse and/or rape in their lifetime. Of Hispanic/Latino women who had sex with a man in the previous year, 73% reported their partner insisted on having sex when they were not interested, 23% report being yelled at, 3% report being hit and 14% report being harmed in some other way during sex. Among Hispanic/Latino men, 68% report that in the past year they have insisted on having sex with a female partner, 30% lied to convince her to have sex, and 51% said she initially resisted, but then changed her mind.

Both men and women reported similar levels of condom use: 34% always use condoms with their steady partner, 70% use condoms the first time they had sex with their most recent partner, and for those with multiple partners in the last twelve months, 47% always used condoms with all partners. Both men and women who hold more traditional gender norms are less likely to use condoms. (3)

Sexuality appears to be even more intensely private and personal in Hispanic/Latino culture than in non-Latino white culture. (5) In traditional Hispanic/Latino culture, the "good" woman is not supposed to know about sex, so it is inappropriate for her to bring up subjects like HIV disease and condoms. (6,7) Recent open-ended interviews suggested that unmarried Latino women fear a man will label them "fast" if they suggest using a condom. At the same time, Hispanic/Latino men may assume no condom is needed if the woman does not suggest it. (5)

The authors recommend that HIV prevention interventions to increase condom in this population include consciousness raising designed to address gender role beliefs and coercive behaviors in men, promote equal decision-making, and provide skills building to increase men's sexual impulse control and self-efficacy to use condoms. Prevention programs should also encourage Hispanic/Latina women to carry condoms more, since carrying condoms is a strong predictor of condom use, and to be more skeptical of new partners. (3)

Participants in a DC focus group with Hispanic/Latina women, held in August 1998, felt cultural characteristics in the Hispanic/Latino community may be barriers to safe sex practices and the dissemination of prevention information. They said machismo may cause many in the community to continue to have sex without a condom, and some wives may be naive of the fact that their husbands are having sex with others and see no reason to use condoms in their marital relations. Some of the older women felt that there is much fear of HIV/AIDS based on a Hispanic/Latino cultural focus on the morbid, which inhibits open discussion of the disease and fosters misinformation. (8)

The most significant problem cited by the group was the lack of information and resources in Spanish other than what is offered by La Clínica del Pueblo. While the young women in the group (with better English skills) felt that there was a good deal of prevention information available and that people just were not paying attention, the older participants said that the information may be available but it does not reach everyone because it is not in Spanish. The need for more prevention services and information in Spanish was voiced several times by group members.

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The number of homeless Americans has increased dramatically since the 1980s. It has been estimated that 13.5 million adults in the U.S. (7.4%) have been homeless at some time during their lives, with 5.7 million adults homeless in the past five years. (1) In the past, many homeless people were former mental patients.

Today, those without housing look disconcertingly similar to those with roofs over their heads. (2) However, homelessness often occurs in combination with chronic mental illness, substance abuse, and unsafe sexual behavior-all factors that heighten the risk of HIV infection. AIDS cases have increased among crack users and injection drug users (IDUs) and people of color-groups that have been traditionally over represented among the homeless. (3)

Homeless people suffer higher rates of many diseases, including HIV, than the general population. A survey of 16 US cities showed a median HIV seroprevalence of 3.4% for homeless adults, (4) compared to less than 1% for the general adult population. In other studies, homeless mentally ill men in New York City, NY had a 19.4% prevalence (5) and in San Francisco, CA homeless adults had a 8.5% rate of HIV infection. (6) For homeless youth across the US, median HIV seroprevalence was 2.3%. (4)

What puts a homeless person at risk?

There are no seroprevalence or behavioral risk studies of the homeless population of the District of Columbia, but a survey of homeless adults entering a storefront medical clinic found that 69% were at risk for HIV infection from either 1) unprotected sex with multiple partners, 2) injection drug use, 3) sex with an IDU partner, or 4) exchanging unprotected sex for money or drugs. Almost half (45%) reported at least two risk factors combined, and one fourth (26%) reported three or more risk factors. (7)

Having multiple sex partners is a risk for HIV, but it may be almost impossible for homeless people to form safe or stable intimate relationships due to drug use, mental illness, violence or transient living situations. A study of homeless women found that 91% were exposed to battery, 56% to rape. (8)

Homeless people, especially women and youth, may engage in survival sex – exchanging sex for housing, food, money or drugs. Substance use can facilitate HIV risks such as forgetting to use condoms, sharing needles with other IDUs, or exchanging sex for drugs. In a survey of homeless adults in St. Louis, MO, 40% of men and 23% of women reported drug abuse; and 62% of men and 17% of women reported alcohol abuse. (9)

What are barriers to prevention?

Homeless populations have been labeled as "hard to reach," but because they are often living and working on the street, they are one of the most visible populations in the US. The biggest barrier to reaching homeless populations is not finding them. But forming trusting relationships and making consistent contact over time to help promote behavior change. (3)

Another misperception is that homeless people cannot be followed. A project at a men's shelter had a 95% follow-up rate 6 months after the intervention. (10) Institutional barriers and settings can restrict HIV prevention activities. Most homeless shelters provide communal

sleeping and bathing, and are therefore single sex, which discourages stable heterosexual relationships. (11)

Staffing at shelters is often only adequate to provide basic needs, and shelters may be reluctant to allow outside HIV prevention programs to talk explicitly about sex and drugs because those activities are forbidden in the shelter. For homeless people living on the street, a lack of private space for counseling and education around sensitive matters can also be a barrier. (3**)**

What's being done?

"Sex, Games and Videotapes" is a program for homeless mentally ill men in a New York City, NY shelter that is built around activities central to shelter life: competitive games, storytelling, and watching videos. For many of these men sex is conducted in public spaces, revolves around drug use, and must be conducted quickly. One component of the program is a competition to see which man can put a condom on a banana fastest (without tearing the condom)-this teaches important skills for using a condom quickly. The program allows for sex issues to be brought up in a non-judgmental way. This program reduced sexual risk behavior threefold. (12)

In San Francisco, CA, HIV tests were offered to homeless people at shelters, food lines and parks, and HIV+ people were given referrals to early intervention. (5) Another testing program was linked to specialized case management to help respond to multiple clients' needs such as access to primary care, substance abuse treatment, and mental health services. Case managers were able to maintain contact and build relationships with drug using clients, many of whom were HIV+ or mentally ill. (13)

A pilot program for homeless women in New York City, NY, some of whom engage in survival sex and are victims of rape and abuse, provides methods of protection women can use in the most difficult circumstances. The women are given Advantage 24 (a time-release Nonoxynol-9 gel) and female condoms, and then learn to use these on a regular basis. As methods they can control, these provide a base for empowerment. (14)

The Teen Peer Outreach-Street Work Project in San Diego, CA, trained teen peer educators to provide HIV prevention education and case management to homeless youth. Food, clothes and shelter information were provided, as well as HIV educational messages. The project found a need for, and subsequently worked to develop, educational materials for homeless youth with low literacy levels. (15)

A successful program for homeless and drug addicted Latina women in Los Angeles, CA, found little difference between women who attended a traditional AIDS education program, and a longer, culturally sensitive program that emphasized problem solving, risk reduction and self-esteem. Shorter, generalized programs may be adequate for addressing more basic needs of impoverished populations. (3)

What needs to be done?

We can learn a lot about HIV prevention for homeless populations by looking at prevention and treatment of tuberculosis (TB) in this population. To successfully treat TB, people need to be housed, fed, and ensured access to clinical care. More attention and funding has been given to TB among homeless people in the last decade because of the risk of infection spreading to the general population. HIV prevention deserves equal dedication and support. (3)

Nontraditional programs are needed that engage homeless populations at every place they access basic services, such as soup kitchens, shelters, hotels, and clinics. Staff who work in these settings should be trained in HIV prevention education. (3)

Group interventions that have worked in certain settings need to be disseminated and replicated in various institutions. Prevention services must have realistic expectations for change, and must give homeless people concrete goals that they can accomplish. It is difficult to conduct HIV prevention without tackling the bigger issue of homelessness. (3)

In 1981, the federal government spent $30 billion on subsidizing low-cost housing; by 1988 that figure had dropped below $7 billion. To stem the tide of the epidemics of homelessness, drug abuse, and AIDS among others, adequate housing, jobs, schools, transportation, day care, nutrition and health care for all is imperative. (2)

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Incarcerated

In 1992, AIDS cases for people in State or federal prisons reached 195 for every 100,000, as compared to 18 for every 100,000 for the general population of the U.S. (1) The incarcerated are the only population in the U.S. that has a constitutional right to health care. High rates of AIDS and HIV infection underscore the need for health care. (2)

Are prisoners at risk for HIV?

Yes. Recent studies show that female inmates, inmates age 25 or younger, and African American and Hispanic inmates are at greatest risk for HIV infection. (3) Injection drug use, other illicit drug use, unprotected sex, and tattooing are all risk behaviors for HIV.

Drug offenses account for the single largest number of Federal crimes for which people are incarcerated. (3) In 1991, 79% of State prison inmates reported using illicit drugs at some time. (4) It is not surprising then, that high rates of HIV infection occur in this population. Injection drug users (IDUs) are at special risk, as clean needles are almost impossible to find both in and out of the prison system. (5)

What are obstacles to prevention?

Participants in a District of Columbia focus group, held at the Lorton correctional institution in July 1998, identified several reasons why people do not practice safer sex, including the thrill and feeling of the sex act, a dislike of condoms, altered judgement due to alcohol and drug use, and determining the level of risk based on the attractiveness or apparent good health of a prospective partner. (6)

Most of the information that the participants had received on HIV/AIDS came from seminars at Lorton and Howard University, and from their doctors. Drug programs at Lorton were mentioned as places where people could receive information about HIV/AIDS, but the participants stated that one must be enrolled in the drug program to receive information.

All participants were aware that condoms were available at the infirmary and did not indicate difficulty in acquiring them. It is not known how the transfer of DC prisons to federal administration will affect the availability of condoms.

Many jail and prison officials do not wish to acknowledge that drug use and sexual activity is prevalent in their institutions. Prisoners also may not wish to acknowledge activities that could subject them to further sanctions. (7)

Prisons and jails would seem to be an ideal venue for drug treatment and education. There are more IDUs in correctional facilities in the US than in drug treatment centers, hospitals, or social services. However, in 1991 only 1% of federal inmates who had moderate

to severe drug abuse problems had received appropriate treatment. Also, for inmates who did complete treatment, there were no aftercare services in place to help them remain drug-free. (8) Lack of outreach and program information to prison staff may have contributed to limited participation.

Only six prison systems in the U.S. distribute condoms: Mississippi, New York City, NY, Philadelphia, PA, San Francisco, CA, Vermont, and the District of Columbia. Methods of distribution vary from receiving one condom per medical visit to receiving multiple condoms as part of HIV/AIDS education. (1) However, distribution programs often send a mixed message because sexual activity in some institutions is illegal and a punishable offense. Also, correctional medical staff may advocate condom availability while administration and security staff oppose it. (5)

Currently, 16 state prison systems mandate HIV testing; 77% make HIV testing available to all inmates on request. (1) Testing HIV-positive while incarcerated could pose two problems: health care is often inadequate to treat HIV infection, and some prisoners fear discrimination or segregation if they are found to be positive. (9)

Why are HIV rates so high?

Most incarcerated people come into jail or prison already infected with HIV. A study of 46 correctional facilities found that people entering correctional facilities had a median infection rate of 1.7%. In some facilities, rates for women were as high as 20.6%, and for men 14.8%. For homosexual and bisexual men, rates ranged from 9.4% to 34.5%; for IDUs rates ranged from 0.6% to 43.1%. (10)

A study of Latino inmates in a California state prison found that 51% reported having sex in the first 12 hours after release. Inmates also indicated the desire for "pure" sex (without condoms) once they leave prison. In addition, 11% reported injecting drugs in the first day after release. (11

What is being done?

State and local health departments provide HIV testing and counseling services in almost 430 correctional facilities in 42 states, the District of Columbia and Puerto Rico. However, health education and risk reduction programs are only provided in facilities in 20 states and the District of Columbia. (12)

At the only prison facility in the state of Rhode Island, a comprehensive program addresses needs of prisoners while incarcerated and follow-up after their release. The program involves HIV education in prison, HIV testing and counseling, medical care for HIV-infected prisoners, and pre-release counseling and post-release monitoring of HIV-infected individuals. Pre-release counseling included medical care, drug abuse, housing, and financial support needs of prisoners. One year after release, 73% of HIV-infected inmates were receiving follow-up medical care. (13)

A community follow-up intervention targeted incarcerated youth aged 13-19 in the District of Columbia. The program reinforced risk-reduction behaviors by providing adult mentoring, peer support, and access to health care services. (12)

Weekly HIV/AIDS education and support groups were set up for female inmates at a facility in New York City, NY. The groups were facilitated by a community-based

organization, and focused on communicating with family members and close contacts about risk behaviors, locating medical care, and other HIV-related information. (12)

Men at a large state prison in California can take part in a comprehensive intervention program that includes: HIV-positive inmate peer education, pre-HIV test counseling, health promotion for HIV-positive inmates, pre-release educational booster session, discharge planning and community follow-up. The success of these programs involves ongoing support and input from inmates, guards and correctional officers, prison counselors, educators, administrators and the prison medical team. (14)

What still needs to be done?

Overcrowding, high turnover, and escalating rates of HIV and other diseases, combined with restricted rights of inmates, create a dangerous public health situation in correctional institutions in the US. Some claim that "the prison population needs access to means of reducing harm more than the general population does." (15)

The pandemic of HIV has paralleled the pandemic of incarceration. Correctional institutions could be an ideal setting for HIV education, prevention, and treatment since inmates are a captive audience. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. In addition to education and treatment in prison or jail, discharge planning is essential to help inmates develop links with their community. Also, ongoing training and education for prison staff (guards, nurses, doctors) is key for ensuring that programs are consistent and sustainable within institutions. (16)

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Injection Drug Users and Substance Abusers

Although sharing used needles is a high risk for HIV transmission, substance abuse and HIV goes beyond the issue of needles. People who abuse alcohol, speed, crack cocaine, poppers or other non-injected drugs are more likely than non-substance users to be HIV positive and to become seropositive. People with a history of non-injection substance abuse are also more likely to engage in high-risk sexual activities. (1)

Many injection drug users (IDUs) use other non-injected drugs primarily. When an IDU is HIV-positive, needle sharing may be the primary risk factor, but other non-injected drug use may have a great effect on risk behaviors. (2) For example, a study of high-risk clients in a methadone treatment program found that those at highest risk for HIV infection were also crack cocaine users. (3)

A survey of heterosexuals in alcohol treatment programs in San Francisco, CA, found HIV infection rates of 3% for men who were not homosexually active or IDUs and 4% for women who were not IDUs. This was considerably higher than rates of 0.5% for men and 0.2% for women found in a similar population survey. (4)

In Boston, MA, a study of gay men found a strong relationship between use of nitrite inhalants or "poppers" and HIV infection. Men who always used poppers while engaging in unprotected anal sex were 4.2 times more likely to be HIV positive than men who never used poppers and engaged in unprotected anal sex. (5)

Crack cocaine use has been shown to be strongly associated with the transmission of HIV. A study of young adults in three inner-city neighborhoods who smoked crack and had never

injected drugs found a 15.7% HIV rate. Women who had recently had unprotected sex in exchange for money or drugs, and men who had anal sex with other men were most likely to be infected. (6)

Since the epidemic began, injection drug use has directly and indirectly accounted for more than one-third (36%) of AIDS cases in the United States. (7) This disturbing trend appears to be continuing. Of the 60,634 new cases of AIDS reported in 1997, 19,463 (32%) were IDU-associated. Eleven percent of these cases were among men and women whose sex partners were IDUs.

IDU-associated AIDS has a greater impact on women than on men. Since 1981, at least 61% of all AIDS cases among women have been attributed to injection drug use or sex with partners who inject drugs, compared with 31% of cases among men. (7)

In the District of Columbia, injection drug use accounted for 22% of the AIDS cases among adult/adolescent males reported as of December 31, 1998, and for 56% of the cases among adult/adolescent females. (8) Thirty percent of Black males were infected through IDU, compared with 8% for Hispanics and 3% for whites. Among black women, 57% were infected through IDU, compared with 53% for white women and less than 1% for Hispanic women.

Why Are They At Higher Risk?

There are probably a lot of reasons why substance abusers are at higher risk for HIV. The reasons most likely vary by drug and social context-crack abusers may have different risks than alcohol abusers, for example. For non-injecting substance abusers, HIV infection is not caused by drug use but by unsafe sexual behavior. (2)

Recently, observers have found an association between HIV infection, heavy crack use and unprotected fellatio among prostitutes. This may be due to poor oral hygiene and oral damage from crack pipes, high frequency of fellatio, and inconsistent condom use. (9)

Gay male substance abusers in San Francisco, CA identified a number of factors that made safe sex difficult for them, including: perceived disinhibiting effect of alcohol and other drugs, learned patterns of association between substance use and sex (especially methamphetamine use and anal sex), low self-esteem, lack of assertiveness, and perceived powerlessness. (10)

Post Traumatic Stress Disorder (PTSD) may account for high sexual risk-taking activities among female crack users in the South Bronx, NY. In one study, 59% of women interviewed were diagnosed with PTSD due to violent traumas such as assault, rape or witness to murder, and non-violent traumas such as homelessness, loss of children or serious accident. (11)

It is often believed that having unprotected sex while under the influence of drugs or alcohol accounts for substance abusers' HIV risk. However, sexual networks and sexual mixing might better explain risk. (12) Many people who are in treatment or using drugs or alcohol are primarily selecting sexual partners from similar networks. They might include people who have used needles, have traded sex for money or drugs, have been victims of trauma, or have been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely. (2)

What Are Obstacles To Prevention?

In American social culture, drug use and sex have become hopelessly linked. For many people, straight or gay, bars are the main method for meeting people. Ads and commercials

portray alcohol as seductive. Honest conversations about sexuality, including homosexuality, are lacking in schools, homes and the media. This can lead to greater sexual inhibitions that might be eased through drinking or using drugs. (2)

The goals of HIV prevention and substance treatment are often conflicting. Many treatment programs focus on stopping substance abuse altogether, and 12 Step programs often advocate sexual abstinence while in recovery. On the other hand, many prevention programs focus on safer sex and harm reduction, acknowledging that relapse could occur. These conflicting cultures may make it difficult to integrate HIV prevention interventions into substance abuse programs. (2)

What's Being Done?

New Leaf (formerly 18th Street Services) in San Francisco, CA, provides substance abuse treatment for gay/bisexual men, and offers a safer sex intervention. Although evaluation of the intervention showed little difference between men who participated in the safer sex program, and men who only went through treatment, both groups showed significant reductions in sexual risk. (13) Getting and retaining substance abusers in treatment is an effective preventive method; adding a safer sex program may also help.

Some prevention efforts teach safer sex behaviors regardless of drug use. In "Sex, Games, and Videotapes," a program for homeless mentally ill men in New York City, NY, the men suggested taping condoms to their crack pipes as a reminder for sexual encounters that are often quick and public. They also compete to see which man can put a condom on a banana fastest (without tearing the condom), which teaches important skills for using a condom quickly. The program allows for sex issues to be brought up in a non-judgmental way, and reduced sexual risk behavior threefold. (14)

Many substance abusers receive treatment only after they have been arrested and are offered treatment as an alternative to jail or prison, or while they are incarcerated. The Delaware correctional system has instituted a therapeutic community (TC) treatment program in prison and a transitional TC outside the prison for parolees. The drug-free residential program includes rehabilitation, peer education group counseling and social services. Participants in the TC program had lower rates of drug relapse and re-arrest than non-participants, and reported reduced HIV risk behaviors. (15)

What Still Needs To Be Done?

Gender specific programs are needed that address women's substance use needs. Women have a higher physical vulnerability to alcohol and higher levels of traumatic events associated with substance use than men. (16) Gay and lesbian-specific treatment is also needed. In addition, specific treatment is needed for drugs such as crack cocaine and new drugs as they arrive on the scene.

Prevention programs for substance abusers need to be integrated into existing services. The HIV epidemic has closely paralleled the epidemics of substance use and incarceration. Substance treatment agencies and prisons and jails need training and authority to incorporate HIV prevention education into their programs. Funders should increase funds and require substance abuse programs to expand treatment to include HIV education. (2)

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Seniors

More than 10% of all new AIDS cases in the U.S. occur in people over the age of 50. (1) In the last few years, new AIDS cases rose faster in middle age and older people than in people under 40. (2) While many of these AIDS cases are the result of HIV infection at a younger age, many are due to becoming infected after age 50. (3)

In the District of Columbia, 983 cases if AIDS had been reported among men 50 or older as of December31, 1998, 9% of the total number of AIDS cases and 11% of the cases among adult/adolescent males. There were 155 cases of AIDS among women 50 or older, 1% of the total number of cases and 8% of the cases among adult/adolescent women. (4)

It is difficult to determine rates of HIV infection among older adults, as very few persons over the age of 50 at risk for HIV routinely get tested. (3) Most older adults are first diagnosed with HIV at a late stage of infection-when they seek treatment for an HIV-related illness. (5)

Cases among older people may be under reported, as HIV symptoms and infections may coincide with other diseases associated with aging, and thus be overlooked. AIDS-related dementia is often misdiagnosed as Alzheimer's, and early HIV symptoms such as fatigue and weight loss may be dismissed as a normal part of aging. (6)

Older persons with AIDS get sick and die sooner than younger persons. This is due to late diagnosis of the disease as well as co-infection with other diseases that may speed the progression of AIDS. (7) Also, new drugs for HIV treatment may interact with medications the older person is taking to treat pre-existing chronic conditions.

What puts them at risk?

A common stereotype in the U.S. is that older people don't have sex or use drugs. Very few HIV prevention efforts are aimed at people over 50, and most educational ad campaigns never show older adults, making them an invisible at-risk population. (8) As a result, older people are generally less knowledgeable about HIV/AIDS than younger people and less aware of how to protect themselves against infection. This is especially true for older injecting drug users, who comprise over 16% of AIDS cases over 50. (5)

Men who have sex with men (MSM) form the largest group of AIDS cases among adults over 50. (16 **5**) In the District of Columbia, 48% of the cases of AIDS reported among adults/adolescents of December 31, 1998 were among MSM. (4) Older gay men tend to be invisible and ignored both in the gay community and in prevention. Among the HIV risk factors for older gay men are internalized homophobia, denial of risk, alcohol and other substance use, and anonymous sexual encounters. (9)

Women comprise a greater percentage of all AIDS cases as age increases. While 6.1% of all AIDS cases among those aged 50-59 are women, the percentage of cases occurring among women rises to 13.2% for age 60-69 and 28.7% for those 65 and older. (10) Normal aging changes such as a decrease in vaginal lubrication and thinning vaginal walls can put older women at higher risk for HIV infection during unprotected sexual intercourse. (11)

What are barriers to prevention?

A District of Columbia focus group with 16 African-American seniors, held in September 1998, found that most participants were not well informed about HIV/AIDS issues. In their responses to a self-administered questionnaire, only seven of the participants said they were familiar with HIV prevention methods and only two knew of any HIV/AIDS programs. None of the participants had ever considered being tested for HIV infection. (12) There was a consensus among the participants that none of the information they had obtained on HIV/AIDS was designed with the issues and concerns of older people in mind.

Few Americans over age 50 who are at risk for HIV infection either use condoms or get tested for HIV. In a national survey, at-risk people over 50 were one sixth as likely to use condoms and one fifth as likely to have been tested for HIV than at-risk people in their 20s. (3) Factors that influence condom use in older persons are not known.

Doctors and nurses often do not consider HIV to be a risk for their older patients. A study of doctors in Texas found that most doctors rarely or never asked patients older than 50 years questions about HIV/AIDS or discussed risk factor reduction. Doctors were much more likely to rarely or never ask patients over 50 about HIV risk factors (40%) than they were to never or rarely ask patients under 30 (6.8%). (13)

Many older people live in assisted living communities, where there is still great stigma attached to HIV/AIDS, often associated with homosexuality and/or substance abuse. Management may be resistant to providing HIV/AIDS educational materials or presentations in their facilities. (5)

How are older adults different?

Cultural and generational issues need to be considered in crafting HIV prevention efforts. Older persons may not be comfortable disclosing their sexual behaviors or drug use to others. This can make it difficult to find older adults who attend support groups. (14) Also, older adults may not view condom use as important or necessary, especially post-menopausal women who need not worry about pregnancy protection.

Older adults may have fewer surviving friends and a smaller social network to provide support and care. Also, they are more likely to be caregivers themselves, as about one third of AIDS patients are dependent on an older parent for financial, physical or emotional support. (15)

What's being done?

Unfortunately, few prevention programs exist that target adults over 50. Most programs for older adults offer support for HIV+ persons, or target clinicians and caregivers of older adults. Promising prevention programs incorporate generational concerns, target high-risk groups such as older gay men and older women (especially recent widows), and involve older adults in their design and as peer educators. (5)

Senior HIV Intervention Project (SHIP) in Florida's Dade, Broward and Palm Beach Counties, trains older peer educators to present educational and safer sex seminars at retirement communities. Trained AIDS educators meet with health care professionals and aging services workers to help them understand the risk posed to seniors by HIV. (16)

In six regional senior centers in Chicago, IL, a program used peer-led "study circles" to increase HIV awareness and knowledge. Participants viewed a video, "The Forgotten Tenth,"

and did their own research as to how HIV affects their lives physically, politically and economically. They then shared their knowledge at the next meetings. After the program many participants became AIDS educators. (17)

An HIV education program for older adults was conducted at meal sites in Florida. Based on the Health Belief Model, the program included facts and statistics on older persons and HIV, condom use instruction, HIV testing information, and case studies of older persons with AIDS. After the session, participants reported a significant increase in knowledge about AIDS and perceived susceptibility to HIV. (18)

What needs to be done?

Prevention programs are needed specifically for older adults. Mainstream ad campaigns need to incorporate images and issues concerning persons over 50 and encourage at-risk older adults to be routinely tested for HIV. More research on sexual and drug using behavior of older adults is needed. (5)

Clinicians and service providers for older adults, including care takers and nursing home staff, need to be educated on HIV risk behaviors and symptoms of HIV infection among older adults. Clinicians need to conduct thorough sex and drug use risk assessments with their patients over 50, and challenge any assumptions that older people do not engage in these activities or will not discuss them. (5)

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Transgendered

There is little research that has examined HIV risk and the health, prevention, and social service needs of transgendered persons. But a 1996 study in San Francisco among female-to-male transgendered individuals found high rates of HIV risk behaviors, including unprotected sex, commercial sex work, and injection drug use. (1) Study participants cited low self-esteem, substance abuse, and economic necessity as common barriers to adopting and maintaining safer behaviors. Participants also stated that fear of discrimination and the insensitivity of service providers were the primary factors that keep them from accessing HIV prevention and health services.

The term transgendered is used to describe individuals who adopt a gender identity that is not congruent with their original physiological status. This group includes pre-, partial- and post-operative transsexuals, transgenders, transvestites, cross-dressers, and those who are intersexed (born with ambiguous genitalia and/or sex chromosomes). (1) While transgendered individuals all have significant psychological and emotional cross-gender identification, their behavior and sense of personal identity varies. Further, sexual orientation is distinct from gender identity; transgendered persons may be lesbian, gay, bisexual, heterosexual, and asexual.

Some transgendered individuals do not choose to transition into a full-time cross-gender identity because of health and other personal reasons. Life circumstances, such as employment, can also make full-time cross-living difficult or impossible. Other transgendered persons choose to adopt a cross-gender identity as fully as possible, often with the aid of hormones and surgeries. For both transgendered female-to-males (FTMs) and male-to-females (MTFs), transition into the new gender identity may involve a number of steps and can take years. Many transgendered persons are somewhere in the middle of this process, and some may not intend to transition further.(1)

Risk Behaviors

Nearly one-quarter (23%) of the sample in the San Francisco study engaged in commercial sex work, and of these 57% were HIV+. Participants felt that economic necessity and survival was by far the most common contributing factor to the prevalence of sex work among transgendered MTF individuals. Peer pressure, drug addiction, glamour, and validation of one's gender were other incentives to prostitute.

One-fifth of the sample (20%) self-disclosed that they personally engaged in unsafe sexual behaviors. They attributed unsafe sexual behavior to low self-esteem, low self-worth, economic necessity and/or addiction, exploration of their new gender/sexual identity, dishonesty about HIV status (their own or their partner's), increased sex drive (FTMs who were taking hormones), and equating unprotected sex with a deeper relationship than "working".

Almost one fifth of the sample (18%) self-disclosed that they personally had substance abuse problems. Participants felt that the following factors contributed to drug and alcohol abuse: the street lifestyle involving prostitution and drugs, lack of education, low self-esteem, and lack of job opportunities.

Transgendered Individuals in the District of Columbia

There are no seroprevalence or risk behavior studies of transgendered individuals in the District of Columbia, but participants in a focus group for MTF, transgendered commercial sex workers, held in August 1998, identified several risk factors for HIV, including lack of knowledge; low self-esteem; denial of the risks involved in unsafe behaviors; denial of one's own HIV status; prostitution; social marginalization that reduces or eliminates the chances of employment other than prostitution, of "making it," and/or being loved; using the lack of visible symptoms in sex partners as an excuse to have unsafe sex; a desire for material gain or illicit drugs, especially crack; and the impaired judgment from illicit drug use, especially crack. (2) Another risk factor mentioned by the group of 10 African-Americans and one Native American was rape, especially while incarcerated. Several participants said that some male inmates do not care about getting HIV and thus transgendered persons are at increased risk for rape by them when they become incarcerated in the male jails.

The lack of outreach and encouragement by transgendered outreach workers to transgendered people and other underprivileged, hard-to-reach populations in the city was cited as a key factor in accessing services. Hiring of transgendered staff by AIDS service organizations (ASOs) emerged as a key priority of the group and was viewed as a measure of the HIV community's commitment to transgendered HIV positive persons.

Transitional housing was identified as a particularly acute need, as was diversity and sensitivity trainings activities to raise the cultural competencies of ASO staffs, case managers and health care providers. Advocacy needs included transgendered access to legal services, crisis intervention and a 24-hour hotline, and a resource manual for transgendered people. Other needs mentioned included vocational training, transgender-specific educational materials, transportation to improve access to services, and improved case management to facilitate access of services by transgendered people.

Many of the group members complained about their invisibility and called for the gay-dominated HIV community to become more inclusive and to target transgendered people for

more services with better resources. The group felt more education was needed in the form of safe sex seminars and focus groups, peer education, training and referrals through the transgendered support groups.

Prevention Needs

Participants in the San Francisco Study spoke of the difficulties reaching both FTM and MTF persons and the need to reach the sex partners of transgendered individuals, and underscored the value of street-based education, particularly when conducted by transgendered community members empowered as outreach workers. Participants also expressed the need for the availability of a range of safer sex materials, so that assumptions are not made about the sexual behaviors of different transgendered individuals.

Participants discussed the need for media campaigns that educate the transgendered community, and underscored the value of media efforts that target hard-to-reach populations. They wanted to see transgender-specific HIV prevention messages in the media, including FTM specific messages.

MTF individuals expressed the need for counseling and education that builds their self-esteem and FTMs emphasized the need for HIV education that offered validation of themselves as sexual men with new gender and sexual identities. Many participants expressed concern that their specific issues and identities are not addressed in individual counseling sessions. It was suggested that training HIV counselors and educators about transgendered issues would help improve the efficacy of current risk reduction and education efforts. Some participants also indicated the need for educational materials in languages other than English.

Discussion of transgendered single and multiple session groups centered on the need for a space for transgendered persons to talk about the issues and problems that they face. Participants felt that support groups can be an effective tool for HIV prevention education, a means for building self-esteem, and. an opportunity to help clients build job skills to facilitate a transition out of commercial sex work. Participants also stressed the importance of venue-based community events for building a community support system, including street theater, educational forums, community dances, beauty pageants, rallies, potlucks, and garage sales.

Discussion of HIV counseling and testing centered on the difficulty and frustration of accessing HIV antibody testing, and the insensitivity of many counselors who work with transgendered clients. Participants described counselors who made assumptions about clients' gender by not differentiating MTF clients from gay men. Some participants stressed that they would prefer it if service providers asked, rather than assumed, their gender identity. The need for transgender-specific options for gender identity on demographic forms was also highlighted.

Participants expressed concern about the lack of available transgender-sensitive substance abuse treatment services, discrimination and lack of personal safety in existing recovery services, and the lack of sensitivity and knowledge about FTM issues among substance abuse programs and providers.

Recommendations for prevention services

The San Francisco Transgendered Advisory Committee made two major recommendations to improve prevention services for this community, including:

- Hiring and training MTF and FTM transgendered individuals as support group facilitators, client advocates, substance abuse counselors, media campaign coordinators, case managers and outreach workers could facilitate access to services for the transgendered community. Employing transgendered staff would also provide jobs to a community that has suffered severe employment discrimination.

- Transgendered sensitivity training for service providers A training unit responsible for developing and implementing in-service trainings should be formed to ensure that systematic training of all service providers takes place on an ongoing basis.

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Women

In just 12 years, the proportion of all AIDS cases reported among adult and adolescent women nearly quadrupled, from 7% in 1985 to 27% in 1997. (1) HIV/AIDS was the fourth leading cause of death among US women aged 25-44 in 1996 (the most recent year for which complete death information is available), and the leading cause of death among African-American women in this same age group. Women under 30 made up 22% of AIDS cases among women in 1996. Because the time from HIV infection to developing AIDS can be long, many of these women acquired HIV in their teens. (2)

Nationally, heterosexual contact is the leading risk exposure category for all women (40%), and 29% of those are due to sex with an injection drug user (IDU). Injection drug use accounts for 32% of all cases. (2) In the District of Columbia, women account for 17% of AIDS cases among adults/adolescents reported as of December 31, 1998. (3) More than half the women (57%) were infected through injection drug use, and 36% through heterosexual contact.

Nationally, AIDS rates for African American and Hispanic women are 17 and 6 times higher than for white women. In 1997, African American women made up 60% of all female AIDS cases, Hispanics 20% and Whites 19%. (4) In the District, Black women account for 94% of the cases among adult/adolescent women, while white women account for 5% and Hispanic women for 1%. (3)

What places women at risk?

Male-to-female transmission is estimated to be eight times more likely than female-to-male; (5) in 1997, 38% of women contracted HIV through heterosexual contact, as opposed to 7% of

men. Reasons for this are twofold: there are more men than women in the US infected with HIV, which increases the likelihood that women would have an infected sex partner; and HIV is more easily transmitted from men to women due to the greater exposed surface area in the female genital tract. (6)

Sexually transmitted diseases (STDs) other than HIV can increase the risk of new HIV infections at least two to five times. Genital ulcers and immune response associated with STDs make it easier for HIV to enter the body. There are an estimated 12 million new cases of STDs every year, and populations at highest risk for HIV infection also have disproportionately high rates of other STDs. (7)Treatment of STDs can be an effective HIV prevention strategy. Injection and non-injection drug use puts women at increased risk for HIV infection and is strongly linked to unsafe sex. In one study, female IDUs reported sharing needles 32% of the time, and obtained used needles from their regular sex partner 71% of the time. (8) Women who smoke crack cocaine, particularly women who have sex in exchange for money or drugs, are at high risk for HIV infection via sexual transmission. (9)

Sexual abuse and coercion places many women at risk. In one study, physical and sexual abuse were "disturbingly common" throughout life among women at high risk for HIV infection. Childhood sexual abuse (42%) and physical abuse (42%) was also common. Women who have been abused are more likely to use crack cocaine and have multiple sex partners. (10)

What are barriers to prevention?

Women do not wear the condom. For women to protect themselves from HIV infection, they must not only rely on their own skills, attitudes, and behaviors regarding condom use, but also on their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making. (11)

Women are disproportionately represented among the poor. Because of this, women are less likely to have health insurance and access to health care services. Many minority women living in poverty are also disproportionately affected by HIV. For these women, the struggle for daily survival may take precedence over concerns about HIV infection, whose impact may not be seen for several years. (12)

Like many people in committed relationships, women may find intimacy in their relationship to be more important than protection against HIV. Unsafe sex may be linked to emotional and social (not necessarily financial) dependence on men. The ideal of monogamy, including assuming their partner's fidelity, may increase AIDS risk denial. (13)

What are the methods for protection?

Women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives. However, oral contraceptives like the pill do not protect against STDs and HIV. Female-controlled methods to prevent HIV transmission are needed. Traditionally, abstinence, condoms and dental dams have been the main methods of protection. In 1993, Reality®, a female condom, was introduced on the market but to date, results have been mixed as to its efficacy, affordability and interest in use. (2) Vaginal microbicides that would prevent STD transmission but allow for pregnancy have been developed and piloted in some prevention programs. Further efforts need to include large-scale efficacy

trials and to increase scientific interest and support from pharmaceutical companies to develop microbicides that prevent HIV infection. (14)

What is being done?

Recruiting women as community leaders was the basis for an effective HIV prevention program among low-income urban women living in housing developments. Women opinion leaders were trained to lead risk reduction workshops, provide HIV educational materials and condoms, and conduct HIV education through community events. The women effectively mobilized their residential community through tailored prevention messages and activities. (15) Because women at risk are not always visible as a specific population or community, programs must strive to be where women are. A program provided HIV prevention services for women visiting their incarcerated male partners at San Quentin State Prison. The program, based at the visitor's center, trains women visitors as HIV educators, and the educators provide group and individual peer education. The program is low cost and has been well accepted by visitors and by the prison. (16)

Interventions that promote HIV counseling and testing for both members of a couple should be considered. The California Partner Study provided couple counseling in combination with social support to serodiscordant heterosexual couples (where one partner is HIV positive and the other HIV negative). As a result, condom use increased and no new HIV infections were reported among the couples. (16)

Most drug treatment programs are staffed by men and oriented towards male clients. Allowing pregnant women to enroll in drug treatment, and allowing women to bring children with them would be helpful. In San Francisco, CA, a women-only needle exchange program was well accepted and used by female drug users. The number of needles exchanged and number of visits was similar between women who attended the women-only exchange versus mixed gender exchanges. However, women who visited the women-only exchange were more likely to receive health care and to receive additional health promotion services such as food, vitamins, coupons and clothing. (18)

What needs to be done?

Because women are more likely to be infected by men, and AIDS cases due to heterosexual contact are increasing, programs that specifically target men (especially IDUs) will have a beneficial impact on women. Needle exchange and drug treatment are important strategies, since almost half of all infections in women are due to injection drug use. Encouraging women to seek STD diagnosis and treatment should also be a part of effective HIV prevention strategies. (2)

Participants in a focus group for African-American women who reside in public housing projects in the District, held in August 1998, expressed a need for educational programs for younger people, particularly peer programs for teenage girl, especially in public housing projects. (19)

Even if women know how to protect themselves from HIV infection, awareness of the facts must be coupled with the skills and support needed to change behavior. The CDC has made the following recommendations to slow the HIV epidemic among US women: (5)

- **Increase emphasis on prevention and treatment services for young women and women of color.** Many US women reported with HIV or AIDS are unable to identify

their risk for acquiring HIV infection, indicating that they may be unaware of their partners' risk factors. Knowledge about preventive behaviors and awareness of the need to practice them is critical for each and every generation of young women - prevention programs should be comprehensive and should include participation by parents as well as the educational system.

- **Address the intersection of drug use and sexual HIV transmission.** Women are at risk of acquiring HIV sexually from a partner who injects drugs and from sharing needles themselves. Additionally, women who use non-injection drugs (e.g., "crack" cocaine) are at greater risk of acquiring HIV sexually, especially if they trade sex for drugs or money.
- **Better integrate prevention and treatment services** for women across the board, including the prevention and treatment of other STDs and substance abuse and access to antiretroviral therapy.

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Pregnant Women (Pediatric)

Mother-to-infant HIV transmission, also called perinatal transmission, is spread from an HIV+ woman to her baby during pregnancy, in the birth process or by breastfeeding. The chances of an HIV+ woman passing the virus to her child ranges from 16-40% without treatment. (1)

In the District of Columbia, 161 cases of perinatal transmission had been reported as of December 31, 1998, out of a total of 168 pediatric AIDS cases (children 0-12 years of age). (2) The District does not collect data on pregnant women either infected with HIV or living with AIDS, so it is not known how many women may be at risk for delivering an HIV-infected child.

It is possible to help reduce the risk of HIV transmission from mother to child by preventing HIV from occurring in the mother; providing voluntary HIV testing; providing free or low-cost prenatal care; providing access to anti-HIV drugs during pregnancy; encouraging HIV+ mothers not to breastfeed; and providing viable alternatives to breastfeeding. (1)

In 1994, the US Public Health Service recommended HIV counseling and voluntary testing and AZT therapy for all pregnant women. Since then, there has been a substantial decline in perinatal transmission in the U.S., from 901 new cases in 1992 to 516 in 1996. (3)

In 1995, the District's Comprehensive HIV Intervention and Prevention Services (CHIPS) for Families project, of the Office of Maternal and Child Health, developed a "Policy Initiative to Reduce Perinatal Transmission of HIV" that encapsulates the recommendations of the federal Health Resources and Services Administration. In 1996, the agency developed a counseling and testing protocol for pregnant women which has been distributed to health care workers, and in 1998 an agency panel that developed a "Standard of Care" that is expected to be issued by the Department of Health in the Fall of 1999.

The standard includes recommendations that, "All health care providers that provide care to pregnant women and women of childbearing age should provide routine HIV counseling and offer voluntary testing on-site or by referral… provide to all pregnant women with HIV infection clear information on the risks and benefits of treatment for herself and her infant… (and) make available medical treatments intended to reduce perinatal HIV transmission in accordance with current Public Health Service (PHS) recommendation either on-site or by referral."

Perinatal transmission cannot be prevented if a woman is unaware that she is HIV+. In the U.S. many women first find out they are HIV+ during prenatal screening, or once their child is born and tests positive for HIV. Access to voluntary HIV testing and counseling using trained peer counselors must be made available for all women to help them make informed choices. (1)

Treating HIV+ pregnant women with AZT during pregnancy and delivery, and treating the infant with AZT after birth, has been shown to cut rates of perinatal transmission by two-thirds, from 25.5% to 8.3%. (4) However, some women in the may choose not to use AZT, may have problems adhering to the regimen, or may not be able to afford or access the drugs. (5)

Access to good health care both before and after birth is critical to reducing perinatal HIV transmission. (6) Unfortunately, this is not the case for many women in the U.S. (1)

A recent study of 939 babies born to HIV+ mothers in New York state found that even an abbreviated regimen of AZT was effective in reducing HIV transmission. Transmission rates for mothers and babies not receiving AZT was 26.6%, compared to 6.1% when treatment was begun before birth, 10% when begun during birth, 9.3% when begun within the first 48 hours after delivery, and 18.4% when begun after 48 hours. This study has important implications for women without prenatal care or women diagnosed late in pregnancy. (7)

Breastfed HIV- infants of HIV+ mothers are at substantial risk for HIV. One report shows 5% of children in developing countries become HIV+ through breastfeeding, and HIV transmission risk increases 3% per child year as breastfeeding continues. (8) Bottle feeding or breast milk substitutes) may prevent infection of 10% of children exposed perinatally, if safe and available. (9)

At the Bay Area Perinatal AIDS Center (BAPAC) at San Francisco General Hospital, in San Francisco, CA, HIV+ mothers receive antiretroviral therapy and further treatment/control of maternal HIV disease, and babies are given AZT for six weeks following birth. None of the 71 HIV+ mothers transmitted HIV to their infants and none of the mothers breastfed. (10)

HIV is a preventable disease. Perinatal transmission is best prevented by effective, affordable HIV prevention programs for women. However, discussions of perinatal transmission must not ignore the needs of the woman other than as a vehicle for giving birth. Education and empowerment for all women is essential, along with access to good medical care and nutrition for women and their children whether they are HIV+ or HIV-. (1)

Successes in reducing mother/infant HIV transmission in the U.S. give a clear signal that now is the time to act. Funding is needed to secure AZT or other antiretroviral treatment for all HIV+ pregnant women who choose to take it. In addition, all women must have access to voluntary HIV testing and counseling. (1)

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